Synergique Healing, PA

Behavioral Health & Functional Medicine

Authorization To Disclose Or Release of Records

Patient's Name_____ **Date of Birth**_____

Address:_____ **Apt#/Unit**_____

City:_____, **State:**_____ **Zip:**_____ **Phone#**_____

☐ **Send my records to:** ☐ **Request my records from:** ☐ **Allow my providers to collaborate**

Entity: _____

Address: _____**Suite/Unit #:**_____

City:_____, **State:**_____ **Zip:**_____

Phone _____ **Fax** _____

Purpose: I authorize the release of my health information for the following specific purpose:

_____.

Information to be disclosed: I authorize the release of the following health information: (check the applicable box below)

- ☐ All Records
- ☐ Only Dates From: _____ to _____
- ☐ Initial Psychiatric Evaluation
- ☐ Medication Information
- ☐ Progress Notes
- ☐ Psychological Report
- ☐ Laboratory Reports/ Results
- ☐ Other:_____

I grant special authorization for the following information (**Please Initial**) to be shared:

_____ Psychotherapy Notes _____ Alcohol/Drug Abuse

I acknowledge and understand this authorization will waive my rights to confidentiality regarding the information released per this consent. I hereby release Synergique Healing, PA, and its staff from all liability that could arise from the release and disclosure of the information or records. This agreement shall remain in effect for a limit of one year from the date signed unless otherwise stated. Additionally, a photocopy or fax of this authorization is as valid as the original.

This authorization can be canceled upon the patient's written request,; however, any disclosures already made before receiving the patient's request will not receive any effects. In addition, we have no control over how the agency/ person authorized to receive this information under this consent chooses to utilize it.

_____ _____

Signature of Patient (Legal Guardian/Representative) **Date:**

Relationship: _____

If signed electronically, Date of Birth of Signer:_____ Phone#:_____

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