Synergy
Advanced Healthcare LLC

AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned patient or legal representative, hereby authorize **Synergy Advanced Healthcare LLC** to disclose or obtain health information, *including if applicable*, information relating to the diagnosis or treatment of mental illness, drug and/or alcohol abuse, and confidential HIV-related information regarding:

Patient name _____ **Date of birth** _____ **Phone** _____

1 OTHER FACILITY

Information may be: ☐ **Disclosed to** ☐ **Obtained from** **Name / facility** _____

Mailing address _____ **City / State / ZIP** _____

Phone _____ **Delivery:** ☐ Hand-carry ☐ Fax to: _____

2 PURPOSE OF DISCLOSURE OR USE

☐ Medical ☐ Legal ☐ Disability ☐ Insurance

☐ At the request of the patient or legal representative

☐ Other: _____

3 DATES OF SERVICE & TYPE

Date(s) of service _____

☐ Inpatient ☐ Outpatient ☐ Emergency visit

4 REQUESTED INFORMATION

☐ **Complete record** ☐ **Abstract only**

Or specify the reports needed:

☐ History & physical
☐ X-ray report
☐ Consultations
☐ Laboratory report
☐ Operative reports
☐ X-ray films (Radiology)
☐ Discharge summary
☐ EKG report
☐ Billing statement (Patient Accounts)

☐ Other: _____

ACKNOWLEDGMENTS

I understand that my treatment or continued treatment by Synergy Advanced Healthcare LLC is in no way conditioned on whether or not I sign this authorization, and that I may refuse to sign it. I understand that under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus may no longer be protected by federal privacy regulations. I understand that I may inspect or request a copy of the information to be used or disclosed by the recipient.

This authorization will be valid for a period of one year from the signature date below. Medical records will only be released for dates of service which occur prior to the authorization date unless disclosure of a future service date is specifically authorized. I understand that I may cancel this authorization at any time by notifying Synergy Advanced Healthcare LLC in writing, but if I do, it will not have any effect on actions that the releasee took before it received the cancellation.

Copy fees: Synergy Advanced Healthcare LLC may charge a fee for copying and first-class postage to the individual receiving the requested information. Copy fees will be applied in accordance with Connecticut statute at **$0.65** per page.

Signature of patient or legal representative _____ **Date** _____

Printed name _____

If not the patient, relationship: ☐ Parent ☐ Guardian ☐ Conservator ☐ Executor of estate ☐ Power of attorney

☐ Other (legal documentation required as applicable): _____

Note: The confidentiality of psychiatric, alcohol, drug and HIV-related records is required by Connecticut General Statutes and/or Federal Regulations 42 CFR, Part 2. This information shall not be re-disclosed to anyone else without written consent or other authorization as provided in the Connecticut General Statutes and/or Federal Regulation 42 CFR, Part 2. A general authorization for the release of medical information is not sufficient for this purpose.

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