Authorization for Release of Medical Record Information

I, ______________________________, hereby authorize the release of my health information as listed below:

Patient Name: _________________________________ Date of Birth: ____________

Address (street, city, state, zip): ____

Telephone Number: ___________________________

Provider or facility authorized to release information: ____________________________

Address (street, city, state, zip): ____

Entity authorized to receive information: ______Synergy Health Group ____________

Address (street, city, state, zip): _____ 742 E Main St Annville, PA 17003 __________

Dates of Services: • All • Specified Dates: _____________________

Description of Information: • Entire Record • Other: ________________________

Special Records: Include the following medical records if such information is included in my records. Checking the boxes is not a representation that such information exists.

- Include Drug and Alcohol Treatment Records (protected by the Pennsylvania Drug & Alcohol Abuse Control Act, 71 P.S. § 1690.108)
- Include Mental Health Records (protected by the Mental Health Procedures Act, 50 P.S. § 7111)
- Include AIDS/HIV Related Records (protected by the Confidentiality of HIV-Related Information Act, 35 P.S. § 7607)

  • All AIDS/HIV-Related Records

  • Limited AIDS/HIV-Related Records as follows: ____________________

- Include Sexual Abuse/Assault and Domestic Violence Counseling Records (protected by 42 Pa.C.S.A. § 5945.1 and 23 Pa.C.S.A § 6116, respectively)

Purpose of Release of Information: • transferring care • moving • other: _________

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1. This authorization will expire: • date: _________ • event: ______________
   Unless otherwise specified, this authorization will expire 1 year after the date of this request.
2. I understand that I may revoke this authorization at any time by notifying Synergy Health Group. I understand that revocation will not have any effect on actions taken prior to any revocation.
3. This authorization is voluntary.
4. By signing below, I certify that I understand the nature of the authorization.

5. I understand that Synergy Health may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.
6. If mental health records are to be released as permitted by the Mental Health Protection Act, I understand that I have a right subject to 55 Pa. Code § 5100.33 to inspect the material to be released.
7. If AIDS or HIV-related information is being released, this information has been disclosed to Synergy Health from records protected by Pennsylvania law. Pennsylvania law prohibits Synergy Health from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is authorized by the Confidentiality of HIV-Related Information Act. A general authorization for the release of medical or other information is not sufficient for this purpose.
8. By signing below, I authorize the release of the medical information requested and specifically waive the confidentiality protection afforded by Pennsylvania statutory law for the Special Records indicated above.
   This waiver is applicable only to this request and is not meant to be a general waiver.

____ ________________

Signature of Patient of Patient's Representative/Guardian Date

____ ________________

Printed Name of Patient's Representative/Guardian Relationship to Patient

Date Copied and Notified: _________________