Authorization For Use and Disclosure of Medical Information

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. **Note:** *Information and records regarding the treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

Authorization

I hereby authorize: _____

Physician / Healthcare Facility

To release information on _____ (Patient Name) _____ (Patient DOB) regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence, and/or medical records including those from my other healthcare providers that the above-named healthcare provider may hold, by means of mail, fax, or other electronic methods.

To: _____

Name

_____

Address

_____ _____ _____

City State Zip Code

The medical information/records will be used for the following purpose:

_____

_____

_____

This authorization is:

[ ] Unlimited (all records, excluding substance abuse, mental health, HIV diagnosis/treatment)
[ ] Limited to the following medical information:

_____

I also consent to the specific release of the following records:

Drug / Alcohol / Substance Abuse _____ (initial)

Psychiatric / Mental Health _____ (initial)

Test of Antibodies to HIV _____ (initial)

HIV diagnosis / treatment _____ (initial)

Genetic Information _____ (initial)

Duration

This authorization shall be effective immediately and remain in effect until _____
Date

Restrictions

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy or facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

_____ _____

Signature of patient or legal / personal representative

Relationship if other than representative patient

_____ _____

Patient's name (PRINT)

Date

_____

Patient's Date of Birth

_____ _____

Witness name

Witness signature

Please return the completed form to Synergy Orthopedics via email – records@synergysmg.com