SYNERGY Family Physicians
4422 White Bear Ave • White Bear Lake, MN 55110
Phone: 651-287-8780 • Fax: 651-287-8786

AUTHORIZATION FOR RELEASE OF INFORMATION

Health Information **REQUEST FROM**:	☐ Synergy Family Physicians – Dr. Lake / Dr. Perry / Erin Florin,CNP Facility name: _____ Address: _____ Phone: _____ Fax: _____
Health Information **RELEASE TO**:	☐ Synergy Family Physicians – Dr. Lake / Dr. Perry / Erin Florin,CNP Facility/Physician name: _____ Address: _____ Phone: _____ Fax: _____
Patient Information:	Name: _____ Date of Birth: _____ Other Names: _____ Phone: _____ Address: _____ SSN#: _____
Health Information to be Released:	Date(s) treatment was received: _____ ☐ Entire Records ☐ Operative Report ☐ Laboratory Report ☐ History & Physical ☐ X-Ray Film ☐ Pathology Report ☐ Progress Notes ☐ X-Ray Report ☐ Photographs/Videos ☐ Consultative Report ☐ Certified Copy ☐ Others: _____ *Unless specifically excluded, behavioral/mental health information, HIV information, and/or alcohol/drug abuse information appearing in the information selected above will be disclosed. Do not release records/importation related to:* ☐ *Behavioral/Mental Health* ☐ *HIV/HIV related illness* ☐ *Alcohol and/or drug abuse*
Purpose of Disclosure:	☐ Transfer of care ☐ Personal Use ☐ Insurance ☐ Consultation ☐ Legal/Attorney ☐ Other: _____
Authorization:	**This authorization expires on the following date, event or condition:** _____ If I do not specify any expiration date, event or condition, this authorization will expire in one year. **Statement of Authorization:** • I understand that, except for research-related treatment, Synergy will condition my treatment, payment or eligibility for benefits on my signing this authorization • Except to the extent that action has already been taken, I understand that I may revoke this authorization at any time by giving written notification to Synergy. A photocopy/fax of this authorization will be treated in the same manner as the original. • I do not authorize further release to any third party. I understand that once information is released as specified in this authorization, the facility, their employees, and my physician(s) cannot prevent the re-disclosure of that information. I hereby release each of them from any and all liability arising directly or indirectly from disclosure authorized by this consent and any re-disclosure of that information. _____ _____ Signature of Patient/Legal Authorized Representative Date _____ _____ Relationship to Patient Reason Patient Unable to Sign _____ _____ Signature of Witness (*verbal authorization only*) Signature of Witness (*verbal authorization only*) ---------- For Office Use Only ---------- Medical Records Released By: _____ Date: _____ MR#: _____ □ Copies □ Review Original Copy: Medical Records Copy: Patient