SYNERGY
PHYSICAL THERAPY

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Authorization for Release of Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, then the released information may no longer be protected by federal privacy regulations. I give the following individuals permission to receive copies and/or information about my medical history:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that my healthcare and the payment for my healthcare will not be affected by me signing this form. I understand that I may see and receive a copy of the information described on this form if I ask for it, and that I may also have a copy of this form after I sign it. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it won't have any effect on any actions they took before they received the revocation.

Patient Name: _____ Date: _____

Patient Signature: _____