



SYNERGY MENTAL HEALTH SERVICES

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize the release of the following Protected Health Information (PHI) obtained during the services for _____, born _____.

- | | | |
|---|--|--|
| <input type="checkbox"/> Assessments | <input type="checkbox"/> Financial Info | <input type="checkbox"/> Medical History |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Treatment Plan | <input type="checkbox"/> Substance Use |
| <input type="checkbox"/> Benefits | <input type="checkbox"/> Vocational Info | <input type="checkbox"/> Medications |
| <input type="checkbox"/> Other: | | |

The information is to be disclosed from Synergy Mental Health Services

To: _____

For the following purpose: _____

Expiration: This authorization will automatically expire _____ days from the date of signing (but no longer than 12 months) or upon case closure, whichever occurs first.

Revocation: You may revoke this authorization at any time by signing the bottom of the form, except to the extent that action has already been taken in reliance thereon.

Potential for Re-Disclosure: The information that is disclosed under this authorization may be disclosed again by the person or organization that receives the information. The privacy of this information may not be protected under the federal privacy regulations (42 CFR Part 2).

Refusal to sign: Refusal to sign this authorization could, under certain circumstances, limit our ability to provide you with treatment.

Copy: You have the right to receive a copy of this authorization. Electronic copies are provided free of charge.

I understand that by signing this form I am authorizing Synergy Mental Health Services and its employees, contractors, interns, volunteers, or other staff to disclose the listed records that may include information about mental health and substance abuse treatment.

_____ Client / Guardian Name	_____ Client / Guardian Signature	_____ Date
_____ Relationship (If not client)	_____ Client Address	
_____ Synergy Witness	_____ Witness Signature	_____ Date

Please cancel the above authorization to discuss my Protected Health Information.

Client / Guardian Signature _____ Date _____

Synergy Staff Signature _____ Date _____