SYNERGY MENTAL HEALTH SERVICES

1903 S Jones Blvd, Las Vegas NV 89146
Phone 702-966-3121 • Fax 702-951-9385
www.synergymhs.org

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

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

_____	☐ Assessments	_____	☐ Financial Info	_____	☐ Medical History
_____	☐ Progress Notes	_____	☐ Treatment Plan	_____	☐ Substance Use
_____	☐ Benefits	_____	☐ Vocational Info	_____	☐ Medications
_____	☐ Other:	_____			

The information is to be disclosed to Synergy Mental Health Services
From: _____
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 _____