SYNERGY
PHYSICIANS

9070 E Desert Cove Ave Suite
#A102 Scottsdale AZ, 85260
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www.TheSynergyHealth.com

Authorization to Disclose Protected Health Information to Synergy Physicians P.L.L.C.

Patient whose Protected Health Information is sought:

Patient _____ Last Name _____ First Name _____ Middle Initial _____ Date of Birth __MM__ / __DD__ / __YYYY__

Home Address _____ Street _____ City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

Person or entity *from* which Protected Health Information should be disclosed ("Provider"):

Name _____ Name of Person or Entity _____

Address _____ Street _____ City _____ State _____ Zip Code _____ Phone Number _____

Entity *to* which Protected Health Information should be disclosed:

Synergy Physicians P.L.L.C.
9070 E Desert Cove Ave, Suite
#A102
Scottsdale, AZ 85260

Attn: _____

Description of Protected Health Information to be disclosed:

- ☐ Complete Medical Record
- ☐ History and Physical Exam
- ☐ Operative Reports
- ☐ X-Ray Reports
- ☐ Lab Tests
- ☐ Other _____ Specify _____

Purpose(s) of the disclosure:

- ☐ Supplemental Care
- ☐ Second Opinion
- ☐ Transfer of Care
- ☐ Personal Use
- ☐ Insurance Coverage or Payment of Care
- ☐ Workers' Compensation
- ☐ Legal
- ☐ Other _____ Specify _____

I hereby authorize Provider to release Protected Health Information ("Information") to Synergy Physicians P.L.L.C. I understand that this authorization may cover Information relating to: (i) AIDS, HIV, and other communicable diseases; (ii) genetic testing; (iii) psychiatric, mental, and behavioral health and treatment; and (iv) alcohol, drug, and substance abuse and treatment. I understand that I may revoke this authorization at any time by notifying Provider in writing. I understand that any disclosure made pursuant to this authorization before any revocation shall not constitute a breach of my rights of confidentiality. I understand that this authorization will expire One Hundred Eighty (180) days following the date of execution. I understand that a photocopy or facsimile of this Authorization is valid in lieu of the original. I understand that I may refuse to sign this authorization and that Provider will not condition or deny treatment because of my decision.

_____ _____
Signature of the Patient or the Patient's Legal Representative Date

_____ _____
Print Name If not the patient, state your relationship to the patient or describe your authority to act on behalf of the patient