Synergetic Counseling & Wellness
7546 US-30 3rd Floor Irwin PA 15642
Cell: 724-989-6980
Cell: 724-217-6141

Patient Authorization for Disclosure of PHI (Personal Health Information)
RELEASE OF MEDICAL RECORDS

I,_____, wish to obtain a copy of my medical records

or for them to be sent to or discussed with _____.

Reason I am requesting my records: To share pertinent information .

I would like the following released:

_____ Dates and charges of service.

_____ A summary of my sessions and treatment.

_____ My entire record.

_____ Other (explain) _____

Social Security Number: _____

Date of Birth: _____

Phone Number: _____

I understand that if I have any questions about my clinical records, or the content within, I can contact Synergetic Counseling and Wellness, and someone will meet with me to discuss my records.
I understand that my treatment records are protected under the Health Insurance Portability and Accountability Act of 1996 ('HIPAA'), 45 CFR, Parts 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time and that any notice to revoke consent must be in writing.

Signature:_____ Date: _____