Form SFCF 014E
Rev. 09/12/2022

SYNTERO, INC.
AUTHORIZATION FOR RELEASE/EXCHANGE OF INFORMATION

Client's Legal Name (First, M, Last)	**Date of Birth (mm/dd/yyyy)**
Name of Person Completing this Release	**Relationship to Client** ☐ Child ☐ Parent ☐ Self ☐ Other: _____

Hereby grants consent and authorizes:

Syntero, Inc.
(P) 614-600-2708
(F) 614-476-6708
records@syntero.org

To (*please select one*):
➡ ☐Release
⬅ ☐Receive
↔ ☐Both

With (*organization, position or individual*)

Contact Information: (*phone, address, or fax*):

In any of the following forms: ☐verbally; ☐in written form; ☐or both

I authorize the following information to be released (check all that apply):

☐ Attendance ☐ Diagnoses ☐ Diagnostic Assessment
☐ Medication List ☐ Progress Notes ☐ Psychiatric Evaluation
☐ Psychiatric Notes ☐ Summary of Care ☐ Treatment Plan
☐ Other (Specify):

Spanning the following covered dates:
☐ Most recent admission ☐ Past three months ☐ All
☐ From _____ to _____
☐ Other (Specify):

Regarding the following reason(s):
☐ Continuity of Care ☐ Disability Benefit Determination
☐ Legal ☐ Other (Specify):

Indicate here any exceptions, if any, to the information being released:

I understand that I may revoke or cancel this authorization at any time by submitting written revocation in the manner specified by the disclosing entity, except to the extent that the action has been taken in reliance on this authorization. If this authorization has not been revoked, it will expire upon the completion of the treatment, unless I specify a date or event stated below.
Expiration date or event:

Substance use disorder records of Part 2 programs disclosed pursuant to this Consent are protected by federal regulations and cannot be re-disclosed without my written consent unless otherwise provided for in the regulations. Any information disclosed pursuant to this Consent other than substance use disorder records or records protected under another state law may be subject to re-disclosure by the recipient. I might be denied services if I refuse to authorize disclosure of information for purposes of assessment, treatment or payment relating to substance use disorder if refusal is permitted by state law. My refusal to authorize disclosure of information for other purposes will not affect my ability to obtain treatment or services.
If I have authorized disclosure to a generally described group or class of participants in an entity which is not my treatment provider, upon my written request, I must be provided a list of entities to which my information has been disclosed pursuant to that general designation.
Records released pursuant to this authorization request may include information regarding testing, diagnosis, or treatment of HIV/AIDS, psychiatric and/or drug/alcohol treatment, and/or sexual assault. This form is not a patient access request under 45 CFR 164.524. The Client Request for Medical Records is a separate form.

_____ _____
Signature **Date**

If this authorization has been completed by a personal representative or guardian on behalf of an individual, their authority to act on behalf of the individual must be set forth here:

_____ _____ _____
Name **Date** **Staff Signature**

FOR INTERNAL USE ONLY:

_____ _____
Signature of Staff Receiving Release Date Release Was Received

REVOCATION OF AUTHORIZATION FOR RELEASE/EXCHANGE OF INFORMATION

I HEREBY REVOKE MY PERMISSION FOR USE OR DISCLOSURE OF MY PROTECTED HEALTH INFORMATION TO THE ORGANIZATION, POSITION OR INDIVIDUAL SPECIFIED ABOVE. FURTHER RELEASE OF INFORMATION SHALL CEASE IMMEDIATELY.

Signature of Client or Legal Representative _____ **Date** _____

Staff Signature _____ **Date** _____