SYNTERO, INC.

AUTHORIZATION FOR RELEASE/EXCHANGE OF INFORMATION

☐ **Record pull request**

Client Name _____ Client DOB _____

Syntero, Inc.
Records Department
P 614 600 2708
F 614-476-6708

is authorized to:
- ☐ Receive
- ☐ Release
- ☐ Exchange

with:
_____ (Organization/Individual)
_____ (Phone)
_____ (Fax)

Dates of Information to be disclosed covering:
Dates of treatment: From: _____ To: _____ ☐ All
☐ the previous three months ☐ most recent admission ☐ other (specify): _____

I authorize the following information to be released:

☐ Attendance	☐ Progress Notes	☐ Other (specify below)
☐ Diagnoses	☐ Psychiatric Evaluation	_____
☐ Diagnostic Assessment	☐ Summary of Treatment Letter	_____
☐ Medication List	☐ Treatment Plan	_____
☐ Psychiatry Notes	☐ Verbal communications	_____

Indicate here any additional exceptions, if any, to information released: _____

This disclosure/authorization for use is for the following purpose:	This authorization will remain effective for:
☐ Legal	☐ 90 days
☐ Disability benefit determination	☐ 180 days
☐ Continuity/coordination of care	☐ Expires upon completion of treatment
☐ Other	☐ Other (Specify):

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 If this authorization has not been revoked, it will expire on the date or completion of the event stated above. If no date or event is specified above, this authorization will expire upon completion of treatment.

Substance use disorder records of Part 2 programs 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.

SIGN

Signature of Individual/Guardian/Personal Representative	Date Signed	Print Name

If this authorization has been signed by a personal representative or guardian on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here: _____

Staff Signature _____ Date _____

REVOCATION OF AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby revoke my permission for use or disclosure of my protected health information to the party specified above. Further release of information shall cease immediately.

Signature of client/legal representative _____ Date _____ Signature of Staff _____ Date _____

DATE ICR MARKED TO NOTE REVOCATION: _____

RVSD 4/20