SYNTERO, INC.
AUTHORIZATION FOR RELEASE/EXCHANGE OF INFORMATION

Client's Legal Name _____ Client's DOB _____

Syntero, Inc. Records Department (P 614-600-2708 F 614-476-6708 records@syntero.org) is authorized to *(check only one):*

☐ **Exchange With (Release to and Receive From)** ☐ **Release To** ☐ **Receive From**

WITH:

(Organization) _____ (Phone) _____

(Individual/Position) _____ (Fax) _____

Reason for Request:

☐ Continuity of Care ☐ Legal ☐ Disability Benefit Determination ☐ Other (specify): _____

Dates of Information to be Disclosed Covering:

☐ The previous three months ☐ Most recent admission ☐ All

☐ Dates of treatment from _____ to _____ ☐ Other (specify): _____

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

☐ Verbal Information ☐ Written Information

Information I authorize to be disclosed includes:

☐ Attendance ☐ Diagnoses ☐ Diagnostic Assessment

☐ Medication List ☐ Progress Notes ☐ Psychiatric Evaluation

☐ Psychiatric Notes ☐ Summary of Care ☐ Treatment Plan

☐ Other (specify):_____

Indicate here any additional exceptions, if any, to information 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 If this authorization has not been revoked, it will expire on the date or completion of the event stated below. If no date or event is specified below, this athorization will expire upon completion of treatment.
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.

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: _____

If personal representative or guardian signed, the Syntero staff member who verified their identity will sign here: _____

FOR INTERNAL USE ONLY:

Signature of Staff Member Receiving Release _____ Date Release Was Received _____

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 3/2019

A Part 2 Program is a federally assisted: (i) individual or entity other than a general medical facility who holds itself out as providing, and provides, substance use disorder (SUD) diagnosis, treatment; (ii) an identified unit within a general medical facility that holds itself out as providing, and provides, SUD diagnosis treatment, or referral for treatment; or, (iii) medical personnel or staff in a general medical facility whose primary function is provision of SUD diagnosis, treatment, or referral for treatment, and who are identified as such providers.
This form is not a patient access request under 45 CFR 164.524. *Records released pursuant to this authorization may include information including testing, diagnosis or treatment of HIV/AIDS, psychiatric and/or drug/alcohol treatment, and/or sexual assault.*