# Synergy Rehab

## Authorization for Release of Information to a 3rd Party

Name:_____ DOB: _____

Address: _____

City, State, Zip Code : _____

Phone: _____ E-mail: _____

I _____ authorize the following medical information to be securely delivered via the approved method from **Synergy Rehab, OT LLC** to:

Name of 3rd Party: _____

Address: _____

City, State, Zip Code: _____

Phone: _____ Fax: _____

**Purpose of Release of Information**: check all that apply

- ☐ Forms
- ☐ Legal
- ☐ Continuation of Care
- ☐ Insurance
- ☐ Other _____


**Delivery Method**: check all that apply

- ☐ Fax
- ☐ Mail
- ☐ Printed or written copy
- ☐ Email
- ☐ Pick up
- ☐ Other: _____

**Records to be Released**: check all that apply

- ☐ Evaluations, Assessments, Discharges
- ☐ Treatment notes
- ☐ Functional outcome testing
- ☐ Demographics including possibly copies of identification and insurance cards
- ☐ MD records, Orders, Prescriptions
- ☐ Specifics on records to be released: _____

**Signature and Authorization for release of records**:initial all boxes to state understanding of each statement

- ☐ I understand this agreement is valid for 1 year from time of completion (unless other date is specified)
- ☐ This authorization may be revoked at any time by providing written notice to Synergy Rehab, OT LLC
- ☐ I may be charged with copies of my medical records in accordance with state Law
- ☐ I have the right to request, obtain, and inspect my medical records that may be disclosed at any time and will provide 10 business days notice.

**Signature**: _____**Date**: _____

**Name** (Print): _____

**Relationship**: _____

*a client 18 years and old must sign and release information for themselves unless they have been deemed incapacitated or deceased.*