SYNERGY
PHYSICIAN GROUP, P.A.

The Leader in Spinal Medicine and Minimally Invasive Spinal Surgery

457E Bypass 123
Seneca, SC 29678

Phone: (864) 886-9888
Fax: (864) 886-9777

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

Patient Name:_____ Date:_____

Patient Account #:_____ DOB:_____SS#:_____

Patient Address_____

City_____State_____Zip_____

To:_____
(Name of Institution Holding Records)

Address:_____

City:_____ State:_____ Zip:_____

I AUTHORIZE YOU TO RELEASE RECORDS TO: SYNERGY PHYSICIAN GROUP, PA
457E BYPASS 123
SENECA, SC 29678

FOR THE PURPOSE OF:_____
(Reason for Releasing Information)

Release the following portion(s) of patient's medical record during the time period of _____

_____Entire Medical Record

_____Specific Record

_____

This authorization will remain in effect for 1 year, at which time the consent will expire unless revoked earlier. This authorization can be revoked in writing by patient at any time.

By signing this authorization, the undersigned agrees NOT to disclose or make copies of indication information, unless further disclosure is expressly permitted by necessary implication inherent in the purpose of the original consent or authorization.
Proposed new use of information without additional written consent of the person to whom it pertains is prohibited

The undersigned hereby releases the above mentioned institution from any liability which may arise from release and/or examination of the information indicated above. I understand that if there is a charge for copies, that such charges must be paid prior to release of copies.

_____ _____
Patient Signature /Responsible Party Staff Signature