SYNERGY COUNSELING

OF GREENWOOD

Your Path To A Better Life

Medical Records Release Form

I do hereby consent and authorize Synergy Counseling to release and/or receive copies of my medical records.

Patient Name: ______________________ MR#: ______________________

Address: ____

Date of Birth: ______________________ SSN: ______________________

The information you may release subject to this signed release form is as follows:

__ Complete Records	__ Pathology Reports	__ History & Physical	__ Treatment Records
__ Urgent Care Records	__ Radiology Reports	__ Clinical Notes	__ Discharge Summary
__ Emergency Room Records	__ Operative Reports	__ Nurses Notes	__ Lab Reports
__ Hospital Records	__ Physician Orders	__ Progress Notes	__ EKG, EEG, EMG
__ Medication Records	__ Doctor Consults	__ Plan of Care	__ Other ____________

Records Requested From:

Name of Person or Facility____

Practice Address____

Phone #: ______________________ Fax # ______________________

Email address: ____

Disclose Records To:

Name of Person or Facility____

Practice Address____

Phone #: ______________________ Fax # ______________________

Email address: ____

The purpose/reason for this release of information is as follows:

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Patient Signature: ______________________________

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