SYNERGY COUNSELING
OF GREENWOOD
Your Path To A Better Life

Medical Records Release Form - Out

I consent to and authorize Synergy Counseling of Greenwood to release copies of my medical records:

Patient Name: _____

Address: _____

Date of Birth: _____ **SSN:** _____

The information you may release subject to this signed release form is as follows: ***PLEASE INITIAL BY EACH ONE***

_____ Complete Encounter Records/Notes

_____ Appointment History

_____ Certificates of Completion

Records Requested From:

Name of Person or Facility: Synergy Counseling of Greenwood

Practice Address: 101 E. Cambridge Ave Greenwood, SC 29646

Phone Number: 864-223-2243 **Fax Number:** 864-223-3044

Email address: admin@synergycounselinggreenwood.com or synergycounselingmanagement@gmail.com

Disclose Records To:

Name of Person or Facility: _____

Practice Address: _____

Phone Number: _____ **Fax Number:** _____

Email Address: _____

The Purpose/Reason for This Release of Information is as Follows:

_____

_____

Patient Signature: _____

Today's Date: _____