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:

_____

_____

Patient Signature: _____

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