AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

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I, ______________________________ (name of patient), ______________________________ (DOB), authorize SynerGenius Telepresence to disclose protected health information to______________________________ (name of entity or individual), ______________________________ (Address), ______________________________ (City, State Zip) ______________________________ (Fax number), ______________________________ (Phone number) concerning my treatment from _______________ to _______________, (Dates of Treatment), and limited to the following information (initial all that apply):

_______ All responsive information within the patient record
_______ Admission and Discharge summaries
_______ Test results
_______ Progress notes
_______ Consults
_______ Other (please specify) ______________________________.

SPECIAL LIMITATIONS. This Authorization <u>excludes</u> (check all that apply):

_______ HIV/AIDS test results (if part of the specified record)
_______ Substance abuse treatment records
_______ Other exclusions (be specific) ______________________________.

This information is to be used for the purpose of: ______________________________.

I understand that I can cancel this authorization at any time by sending a letter to the Privacy Officer of SynerGenius Telepresence. If I do this, it will prevent any disclosures of my information after the date it is received but cannot change the fact that some information may have been disclosed before that date.

I understand that I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or my eligibility for benefits.

I understand that I may inspect and obtain a copy of the health information described in this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by the federal privacy regulations, the information may be re-disclosed and is no longer protected by those regulations.

I agree that everything in this form that was not clear to me has been explained, that I have been able to ask questions about it, and I believe I now understand all of it.

This authorization is valid as of the date it is signed and continues in effect for one year. By signing this authorization, I acknowledge that I have received a copy of this form.

______________________________ ______________________________
Patient Signature or Signature of Personal Representative Date

____
Print Patient Name

______________________________ ______________________________
Print Personal Representative Name Date
Authority: _____Parent/Guardian _____HCPOA/POA

______________________________ ______________________________
Signature of Witness Date