LifeScape

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS TO THIRD PARTIES

Patient whose Protected Health Information is to be disclosed:

Patient Last Name First Name Middle Initial Date of Birth MM / DD / YYYY

Home Address Street City State ZipCode

Home Phone _____ Work Phone _____ Cell Phone _____

I hereby authorize LifeScape to disclose my Protected Health Information to:

Name Synergy Physicians Name of Doctor, Medical Office or Entity

Address 9070 E Desert Cove Ave #102, Scottsdale, AZ 85260 Street City State Zip Code

Phone 480-372-3473 Fax Number 480-591-8123

Description of Protected Health Information to be disclosed:

- ☐ Complete Medical Record
- ☐ History and Physical Exam
- ☐ Operative Reports
- ☐ X-Ray Reports
- ☐ Lab Tests
- ☐ Other _____ Specify _____

Purpose(s) of the disclosure:

- ☐ Supplemental Care
- ☐ Second Opinion
- ☐ Transfer of Care
- ☐ Personal Use
- ☐ Insurance Coverage or Payment of Care
- ☐ Workers' Compensation
- ☐ Legal
- ☐ Other _____ Specify _____

I hereby authorize LifeScape to release Protected Health Information ("Information") to above Third Party Entity. I understand that this authorization may cover Information relating to: (i) AIDS, HIV, and other communicable diseases; (ii) genetic testing; (iii) psychiatric, mental, and behavioral health and treatment; and (iv) alcohol, drug, and substance abuse and treatment. I understand that I may revoke this authorization at any time by notifying Provider in writing. I understand that any disclosure made pursuant to this authorization before any revocation shall not constitute a breach of my rights of confidentiality. I understand that this authorization will expire One Hundred Eighty (180) days following the date of execution. I understand that a photocopy or facsimile of this Authorization is valid in lieu of the original. I understand that I may refuse to sign this authorization and that Provider will not condition or deny treatment because of my decision.

_____ _____

Signature of the Patient or the Patient's Legal Representative Date

_____ _____

Print Name If not the patient, state your relationship to the patient or describe your authority to act on behalf of the patient.

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