SYNERGYMED

# HIPAA Privacy Authorization and Acknowledgement Form

Authorization for Use or Disclosure of Protected Health Information
(Required by Health Insurance Portability and Accountability Act—45 CFR Parts 160 and 164)

I acknowledge that I have the right to authorize access and disclosure of my Protected Health Information (PHI) to anyone of my choosing for billing, discussion of medical conditions and treatment, medications, and prognosis. I give SynergyMed permission to speak to the following individual(s) about my care as described above.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. Unless otherwise revoked, this authorization shall be in force and effect until one year from today's date at which time this authorization expires.

I understand that I am entitled to a copy of Synergy Med's Notice of Privacy Practices and acknowledge that I received them. I can access a copy of the Notice of Privacy Practices from the office directly.

Date of Birth: ____/_____/_____ Email Address: _____

Signed by _____ Date _____

Print Name _____ Relationship to Patient _____

Patient Name _____ Patient Date of Birth _____

**For Office Use Only:**
Complete the following only if the Patient refuses to sign the Acknowledgment:

Efforts to obtain:
_____
_____

Reasons for refusal:
_____
_____