SYNERGY
LIEN RESOLUTION SERVICES

Authorization to Disclose Health Information

In Compliance with HIPAA 45 CFR §164.508

Patient Name:_____

Social Security Number: _____ -_____-_____

Date of Birth:_____

Personal Representative (if applicable):_____

Relationship to Patient:_____ *Please provide Power of Attorney or Executor documentation.*

I give my expressed permission to _____(name of insurer, provider or other lienholder) to disclose all protected health information for the purpose of healthcare lien resolution and subrogation to:

Synergy Settlement Services
Lien Resolution Services
911 Outer Road, Orlando, FL 32814

Phone: (877) 907-5436
Fax: (877) 408-8194

Information to be disclosed (check all that apply):

____ Complete conditional payment or claim summary pertaining to patient date of loss _____
____ Entire patient medical records, treatment, patient history and any other documents relating to my medical care or treatment at any time
____ Health plan description for insurers who may have made payments for which subrogation may be required.
____ Only the following limited records or information:

_____
_____

This protected health information is being used or disclosed for the following purposes:

_____
_____

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

I have the right refuse to sign this authorization. I understand that authorizing the disclosure of my health information is voluntary. My refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

I have the right to inspect or copy the protected health information to be used or disclosed under this authorization. Unless otherwise revoked, this authorization will expire on _____, or two years after the date of signature.

Finally, I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must send written notification to Synergy Lien Resolution Services, 911 Outer Road, Orlando, FL 32814. I also understand that any written revocation will not apply to actions taken by the requesting person/entity prior to the date the notification is received.

_____ _____
Signature of Patient or Personal Representative **Date**