



MEDICAL RECORDS RELEASE FORM

To request the release of medical information, please complete and sign this form, and fax it to 561-354-2744.

Release my protected health information to:

Name: _____

Fax: _____ Phone: _____

If you would like the records mailed, provide the address below.

Address: _____
Street City State Zip

Reason for release: _____

Restrictions (if any): _____

I hereby authorize Nationwide Synergy, Inc. (NSI) to release my medical information as requested above. This authorization will remain active for one year from date of signature, unless revoked in writing. I am aware that NSI cannot control how the recipient uses the information, and that laws protecting its confidentiality at NSI may not protect this information once it has been disclosed to the recipient. Information will not be released without a valid signature below.

Print Your Name

Your Signature

Date