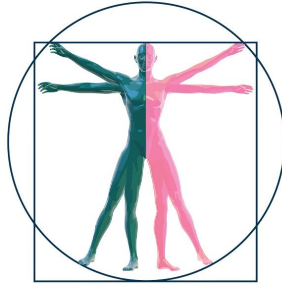

LYONS
CARE ASSOCIATES
"for the hope that lives in you"

Authorization for ____Lyons Care Associates, LLC____ to Disclose My Health Information

Patient Name:____ DOB:____/____/______
Also Known As:____ Phone #: _(___)_______________

You May Disclose the Following Healthcare Information (check all that apply)

- ☐ All my health information maintained by _Samuel D Lyons, MD; Heidi Sarkozy, PAC; Lisa Lombardi, PAC_.
- ☐ My health information relating to the following treatment/condition:________________________________
- ☐ My health information for the date(s):____
- ☐ Other:____

You May Disclose This Health Care Information To

Lyons Care Associates, LLC 1830 Wells St. Ste:103 Wailuku HI 96793
P: 808-866-5335 F: 808-866-5330

Purpose for Disclosure (check all that apply)

☐ Changing Physicians ☐ Continuing Health Care, ☐ School ☐ Insurance ☐ Legal ☐ Workers Compensation ☐ Consultation/Second Opinion
☐ Other (specify):____

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by **Lyons Care Associates, LLC** based upon this authorization. I may not be able to revoke this authorization if its purpose is to obtain insurance. For questions on how to revoke this form please contact us in writing or by phone with questions. Once this office discloses health information, the person or organization that receives it may redisclose it. Privacy laws may no longer protect it. This authorization will expire in 60 days from date of signature. A fax or copy of this authorization may be used as an original.

_______________________________________ _______________________________________
Patient or legally authorized individual signature Date

_______________________________________ _______________________________________
Printed Name Relationship to patient if signed on behalf of patient