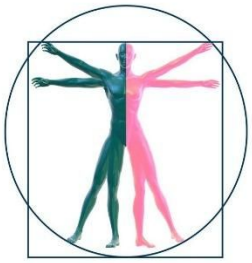

LYONS
CARE ASSOCIATES

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 Lyons Care Associates. I understand that the records may be voluminous and I agree to pay all reasonable charges.
- ☐ 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:

Name(or title) and Relationship (or organization):_____
Address:_____
City:_____State:_____
Zip:_____ Phone #:_(_____)_____ Fax#: _(_____)_____

Purpose for Disclosure (check all that apply)

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

*Personal request for records fee: $15.00 plus tax per chart request for the first 25 pgs, and $0.20 per page thereafter. Records cannot be copied until receipt of this prepayment. Postage is an additional charge. Please make checks payable to **Lyons Care Associates, LLC**. Any request for records will take 5-7 business days after the receipt of authorization and/or prepayment.

I understand I do not have to sign this authorization in order to get health care benefits. However, I do have to sign an authorization form: To take part in research study or to receive health care when the purpose is to create health information for a third party.

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