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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____ / _____ / _____
(Patient's Name - typed or printed) (Social Security Number) (Date of Birth)

Hereby authorize: _____ to release

Protected health information to: _____ / _____
Name of facility to receive information City/State

A. INFORMATION TO BE RELEASED:

(Please be specific and limit information to only that which is absolutely necessary)

Medical History/Examination Surgical Reports Entire Record
 Laboratory Reports E/R Reports Consultations
 Radiology Reports Discharge Summary Other (Specify)

Specify dates needed: _____

In compliance with any applicable state and federal laws, some of which require special permission to release specific types of health information, please release records pertaining to:

Mental Health Developmental Disabilities Alcoholism
 HIV (AIDS) Sexually Transmitted Diseases Drug Abuse

Other: (Specify) _____

Specific Dates Needed: _____

B. REASON FOR DISCLOSURE:

Additional Medical Care Physician Change Insurance Eligibility
 Legal Proceedings Personal

If the person(s) and organization(s) listed above are not health care providers, health plans or health care clearinghouses, which must follow the Federal privacy standards. The health information disclosed as a result of this authorization may no longer be protected by the Federal privacy standards and your health information may be re-disclosed without your authorization.

C. You may withdraw this authorization by written notice. To obtain information on how to withdraw your authorization or to receive a copy of your withdrawal, you may contact an employee of Medical Associates of SE KY.

I have had the opportunity to review the contents of this authorization and my rights in relation to this form. By signing below, I am certifying my agreement with the statements made in this form and agreeing to the release of my protected health information as indicated by this form.

Signature of Patient or Patient Rep.

Printed Name

Date