Lykos Medical

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7610 N.Union Blvd, #150, Colorado Springs CO 80920

Record Release Form

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Name of Patient: _____

Date of Birth: _____ SSN: _____

I authorize the following party (previous medical provider):

_____

to disclose:

- All of my health information
- My health information relating to the following treatment or condition:

  _____

to the folllowing party:

Lykos Medical LLC, 7610 N Union Blvd, #150, Colorado Springs CO 80920

P: 719-434-8810 F:719-960-2909 Email: office@lykosmedical.com

The purpose of this authorization is (check all that apply):

- At my request
- Other: _____

This authorization ends: _____

My Rights:

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature : _____ Date: _____

Printed Name: _____

Relationship to Patient: _____