Michael R. Lyles, M.D.
Diplomate of the
American Board of
Psychiatry and Neurology

LYLES
CRAWFORD
CLINICAL CONSULTING, PC

Mark E. Crawford, Ph.D.
Licensed Psychologist

# Authorization Form

This form when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate.

I authorize Michael R. Lyles, M.D. and/or his administrative and clinical staff to release:

___ my medical record
___ verbal information related to my treatment

Name: _____

Date of Birth: _____

This information should only be released to :

Name: _____

Address: _____

_____

Telephone: _____

Fax: _____

This authorization shall remain in effect until one calendar year from the date of signature or until I revoke this authorization in writing.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ _____
Signature of Patient Date

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.