



RELEASE OF INFORMATION (ROI) AUTHORIZATION

Complete all applicable sections to authorize Lyra Health, Inc. and/or Lyra Clinical Associates P.C. (collectively "Lyra"), as well as the licensed providers delivering care through Lyra's programs, to share your mental health information.

A. Client Name (Person whose information is to be shared)

First, Middle, Last Name: _____

Date of Birth (MM/DD/YYYY): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Lyra Registered Email Address: _____

B. Recipient and Purpose of Release

Recipient(s). I understand the information requested will be released to:

Recipient Name: _____

Organization / Claim # (if applicable): Records Deposition Service

Relationship to Client: n/a

Address: P.O. Box 5054

City: Southfield State: MI Zip Code: 48086-5054

Phone: 248.357.3330 Email : _____ Fax: 248.357.3337
requests@recdep.com

- **Myself:** I want to receive a copy of my records to the following email address:

- **Verbally:** I additionally want to authorize this recipient to follow up with my provider(s) for additional information.
- **Print and send by postal mail if fax and/or email address are not available.**



Purpose of Release. I understand that the information is to be released for the purpose set forth below, or, if none selected, pursuant to my request.

<ul style="list-style-type: none"> Continuity of Care/ Coordination of Care with another Healthcare Provider 	<ul style="list-style-type: none"> Clinical Leave / Disability / Accommodations 	<ul style="list-style-type: none"> Legal (Attorney) <p style="text-align: center;">✓</p>
<ul style="list-style-type: none"> Insurance / Life Insurance 	<ul style="list-style-type: none"> School/ College/ University 	<ul style="list-style-type: none"> Other: _____

C. Records Requested

What information do you want released? Check all that apply.

<ul style="list-style-type: none"> All Records <i>Excludes Treatment Summary Letter and Billing.</i> 	
<ul style="list-style-type: none"> Treatment Summary Letter Only <i>Brief summary of your treatment from provider.</i> 	<ul style="list-style-type: none"> Session Notes Only <i>Detailed notes from your sessions.</i>
<ul style="list-style-type: none"> Leave of Absence / Disability / Accommodations Forms <i>Necessary forms needed to support disability claims or leave of absence requests. We suggest also authorizing All Records.</i> 	
<ul style="list-style-type: none"> Care Management Referral Forms <i>Information needed for your referral with a care manager.</i> 	
<p>➤ Verbal Only <i>This means we can share information about your care verbally with the person or entity you specify. This involves phone conversations rather than written documentation.</i></p>	
<ul style="list-style-type: none"> Other; please specify: <i>If none of the above options fit your needs, please select this and clearly write down exactly what information you would like us to release. Billing can be requested via this selection.</i> <p>Other: _____</p>	

Dates of Treatment.

- All Dates: *includes the full time period of client treatment.*
- Range: Start Date (MM/DD/YYYY) End Date (MM/DD/YYYY)



D. Name of your Lyra Provider(s) or Lyra Care Team member(s):

Check all that apply.

- **All Lyra Providers and Care Team Members associated with my care**

I authorize the release of my protected health information to all Lyra Providers and all members of my Lyra Care Team who currently are or may become involved in providing, coordinating, or supporting my care through Lyra. This includes Lyra providers and care coordinators involved in the delivery or management of my services. This authorization allows for the necessary sharing of information within Lyra to ensure seamless and effective care for me.

- **A Specific Lyra Provider or Care Team Member**

I authorize the release of my protected health information to the following single Lyra Provider and/ or Care Team Member directly involved in my treatment. I understand that this authorization is limited to the named individuals. If I receive care from other Lyra Providers or team members, a new authorization will be required for them to receive or disclose my information.

List Names: _____

E. Sensitive Health Information

Do you specifically authorize the release of the following:

- HIV/AIDS Testing, Diagnosis, or Treatment
- Genetic Testing Information
- Alcohol/Substance Use, Diagnosis, or Treatment

- **Yes**, I authorize the release of any and all sensitive information listed above.

- **No**, do not release any sensitive information unless specifically authorized below:

- **HIV/AIDS Testing, Diagnosis, or Treatment -Yes [] No []**
- **Genetic Testing Information - Yes [] No []**
- **Alcohol/Substance Use, Diagnosis, or Treatment - Yes [] No []**

F. Expiration and Revocation

This authorization will remain in effect for twelve (12) months from the date of signature.

I understand that:



1. I have a right to receive a copy of this form.
2. I have the right to revoke this authorization at any time in writing by contacting Lyra's Records Department at records@lyrahealth.com. I also understand that a revocation will not affect disclosure of health information done in reliance on this authorization prior to it being revoked.
3. Information disclosed because of this authorization may be subject to re-disclosure and no longer protected by federal law.
4. I may refuse to sign this authorization without affecting my ability to obtain treatment services.
5. If this authorization is given by a parent or legal guardian on behalf of a minor, it will expire on the minor's eighteenth birthday.

G. Signature

If signed by a Personal or Legal representative or if signed outside of Lyra's secure platform, a notarized copy of this form must be submitted.

Signature of Client: _____ Date: _____

Printed Name: _____

Designated Legal Representative only:

Relationship to Client: _____

Documentation submitted to demonstrate Legal Representative Status:
