Lyon-Martin Health Services





	Teleph	none #	DOB:
SSN:	Address:		
I authorize the use or	disclosure of the above named ir	ndividuals health info	ormation between:
	dress, phone, fax):d/or		
anization/Person(addr	ess, phone, fax): <u>Lyon-Martin Heal</u> <u>Phone: 415-565-7</u>		ket Street, Ste 201, San Francisco, CA 941
FOR COM	IMUNICATION / SENDING D	OCUMENTS /F	RECEIVING DOCUMENTS
The following type and	amount of information may be use	ed or disclosed as follo	ws:
problem list	most recent history & physic	cal most recent	visit notes medication list
allergy list	laboratory results	immunizatio	on record
other:			
	nclude the following protected heal		
HIV/AIDS	Beh	navioral or Mental He	ealth Services
Treatment of al	cohol/drug use Me	ntal Health Records	from (date) to (date)
Reason for release (ie	e: continue care, transfer care, re	cords for self, etc):	
Services has taken action present my written revinsurance company who policy. Unless otherwise revoked fail to specify an expiration I understand that authors	on in reliance on it. I understand the vocation to the Front Desk. I undented the law provides the patient's in this authorization will expire on the foundate or event, this authorization will expire the use and/or disclosure of the law in the law in the law is a successful to the law in the law is a successful the law is a successful the law is a successful to the law is a successful to the law is a successful	hat if I revoke the auderstand that the revolutions are with the right ollowing date or eventing expire in 90 days from this health information	is voluntary, and that patient's
treatment, payment, an this authorization, exce	d enrollment in a health plan, or eli pt as listed below:	gibility may not be cor	nditioned on my agreement to sign
treatment may be cond of creating protected he	itioned on my agreement to sign thi	is authorization. If this the person or organize	ent, provision of the research related s authorization is solely for the purpose ation described below, the provision of his authorization.
recipient and no longer		If I have questions a	be subjected to re-disclosure by the bout disclosure of the patient's health