Lyon-Martin Health Services
1748 Market Street
San Francisco, CA 94102
Phone: 415-565-7667
Fax: 415-252-7512

Authorization for Verbal Discussion of Protected Health Information

Patient Name: _____ **Date of Birth**: _____

Address: _____

Phone/Cell No: _____

I authorize Lyon-Martin Health Services, a program of HealthRIGHT 360, their physicians, nurses, and other clinic staff personnel to discuss my health information, in person or by telephone, with the following person/s or entity involved in my medical care:

_____
Name of organization/provider/facility

_____(_____)_____
Relationship to the patient Phone Number

_____
Complete Address

This authorization will automatically **expire within one year from the date of signature.** I understand that I have the right to revoke this authorization at any time, except where information has already been released in response to this authorization. My revocation must be in writing, signed by me and delivered to this address: Lyon-Martin Health Services 1748 Market Street, Suite 201, San Francisco, CA 94102

_____ _____
Patient Signature Date