Authorization for Use or Disclosure of Health Information

Patient Name:_____Telephone #_____DOB: _____
SSN:_____ Address: _____

I authorize the use or disclosure of the above named individuals health information between:

Organization/Person(address, phone, fax): _____
& or _____
Organization/Person(address, phone, fax): Lyon-Martin, 1735 Mission St, San Francisco, CA. 94103,
Phone: 415-565-7667, Fax: 415-252-7512
___FOR COMMUNICATION /____SENDING DOCUMENTS /____RECEIVING DOCUMENTS

The following type and amount of information may be used or disclosed as follows:

___problem list ___most recent history & physical_____most recent visit notes_____medication list
___allergy list ___laboratory results ___immunization record
___other: _____

This information is to include the following protected health information *(please initial each line)***:**

_____HIV/AIDS _____Behavioral or Mental Health Services
_____Treatment of alcohol/drug use Mental Health Records from____(date) to (date) ____

Reason for release (ie: continue care, transfer care, records for self, etc): _____

I understand that I have a right to revoke this authorization at any time, except to the extent that Lyon Martin Health Services has taken action in reliance on it. I understand that if I revoke the authorization I must do so in writing and present my written revocation to the Front Desk. I understand that the revocation will not apply to the patient's insurance company when the law provides the patient's insurer with the right to contest a claim under the patient's policy.

Unless otherwise revoked, this authorization will expire on the following date or event: _____
If I fail to specify an expiration date or event, this authorization will expire in 90 days from today.

I understand that authorizing the use and/or disclosure of this health information is voluntary, and that patient's treatment, payment, and enrollment in a health plan, or eligibility may not be conditioned on my agreement to sign this authorization, except as listed below:

If this authorization is for provision to the patient of research-related treatment, provision of the research related treatment may be conditioned on my agreement to sign this authorization. If this authorization is solely for the purpose of creating protected health information for disclosure to the person or organization described below, the provision of health care solely for this purpose may be conditioned on my agreement to sign this authorization.

I understand that any disclosure of information carries with it the potential to be subjected to re-disclosure by the recipient and no longer protected by confidentiality rules. If I have questions about disclosure of the patient's health information I can contact Lyon Martin Health Services at P - 415.565.7667, F - 415.252.7512.

_____ _____

Signature of Patient or Legal Representative Date

_____
If signed by legal representative, please specify relationship to patient