CITY & COUNTY OF SAN FRANCISCO

DEPARTMENT OF PUBLIC HEALTH

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

NAME*

DOB*

MRN

SS#

PCP

Patient ID / Label

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and federal law concerning the privacy of such information. **Failure to provide ALL information marked with an asterisk (*) may invalidate this authorization.**

I*, _____ (AKA) _____

authorize *_____ to disclose health information
(NAME OF HOSPITAL OR FACILITY)

obtained in the course of my diagnosis and treatment for the purpose of *_____.

Disclosure requested by DPH facility and/or agent? ❑ No ❑ Yes Purpose? _____

By checking in the spaces below, I specifically authorize the release of the following medical records, if such records exist. Such disclosure shall be limited to the following types of information or dates of treatment. I recognize that if I am disclosing my health information to someone who is not legally required to keep it confidential, it may be redisclosed and may no longer be protected. California law requires that recipients refrain from redisclosing such information except with my written authorization or as specifically required by law.

Dates of Treatment AND/OR Specific Medical Condition: _____

____ Complete medical record(s)	____ Outpatient Clinic Notes	____ Immunizations
____ Discharge Summary	____ Emergency Report	____ Consultation
____ History & Physical	____ Lab tests	____ Pathology
____ Progress Notes	____ X-ray report	____ Other: _____

INITIAL below for protected classes of information:

☐ Mental Health Treatment ☐ Substance Abuse Treatment ☐ HIV/AIDS Test/Treatment

☐ Sexually Transmitted Disease (City Clinic) ☐ Developmental Disabilities

SEND TO:* _____
(NAME AND ADDRESS OF HOSPITAL OR FACILITY) ❑ Address of named facility is located on back of white copy.

MY DPH RIGHTS: I understand that authorizing the disclosure of this health information is voluntary. I may refuse to sign this authorization. I may revoke this authorization at any time. Revocation must be in writing, signed by me or on my behalf by someone with the legal authority to do so and delivered to the DPH or other facility. My revocation will be effective upon receipt, but will not be effective to the extent that the DPH may have acted in reliance upon this authorization prior to revocation. I have a right to obtain a copy of this authorization. I may not be denied treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.

EXPIRATION: Unless otherwise revoked, this authorization will expire in 90 days, on the following event/condition **OR immediately upon fulfillment** for protected classes. EVENT/CONDITION: _____

* _____ * _____ _____
Date **Signature (Patient/Client/Parent/Guardian/Conservator)** Relationship if not Patient/Client

_____ ❑ Interpreter used _____
Witness (Required if Patient/Client unable to sign)

Back of two sides

CONSIDERATION OF MENTAL HEALTH PROVIDER

Provider completes the following if the client is authorizing release of his/her health information subject to the provisions of the Lanterman-Petris-Short Act:

The undersigned physician, licensed psychologist, or social worker with a master's degree in social work who is in charge of the mental health care of this client hereby ❑ APPROVES ❑ DISAPPROVES the release of information and records to the party specified in this authorization.

Note restrictions to release below. If disapproved, please state reasons below.

_____

_____

_____ _____ _____

Date **Physician/Psychologist/MSW Signature** **Degree**

ACKNOWLEDGEMENT OF REVIEW OF PHI:

I, _____, have this date reviewed the medical records of the patient noted on the reverse at _____.

☐ This review has met all my needs and I have no further requests at this time.

☐ This review has NOT met all my needs. I have the following further request:

_____

_____

_____

Signed: _____ Date: _____

☐ **San Francisco General Hospital Medical Center**
Health Information Services, Main Hospital, Room 2B1
1001 Potrero Avenue
San Francisco, CA 94110-3518

☐ **Laguna Honda Hospital & Rehab Center**
Health Information Services, Room B300
375 Laguna Honda Boulevard
San Francisco, CA 94116-1411

Community Health Network Health Center Addresses

☐ Castro Mission Health Center
3850 17th Street
San Francisco, CA 94114-2031

☐ Chinatown Public Health Center
1490 Mason Street
San Francisco, CA 94133-4222

☐ Cole Street Youth Center
555 Cole Street
San Francisco, CA 94117-2800

☐ Larkin Street Youth Center
1138 Sutter Street
San Francisco, CA 94109-5608

☐ Maxine Hall Health Center
1301 Pierce Street
San Francisco, CA 94115-4005

☐ Curry Senior Center
333 Turk Street
San Francisco, CA 94102-3703

☐ Ocean Park Health Center
1351 24th Avenue
San Francisco, CA 94122-1616

☐ Potrero Hill Health Center
1050 Wisconsin Street
San Francisco, CA 94107-3328

☐ Silver Avenue Family Health Center
1525 Silver Avenue
San Francisco, CA 94134-1229

☐ Southeast Health Center
2401 Keith Street
San Francisco, CA 94124-3231

☐ Tom Waddell Health Center
50 Ivy Street
San Francisco, CA 94102-4506

☐ Youth Guidance Center
375 Woodside Avenue
San Francisco, CA 94127-1221

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