## CITY & COUNTY OF SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

NAME\*
DOB\*
MRN

SS#

PCP

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient ID / Label

Completion	of	this	docu	ıment	author	izes 1	the	disclosur	e and	d/or ι	use of	indiv	idually	ide	ntifiable	e he	ealth
information	, as	set f	orth	below	, consis	tent v	vith	California	and	feder	al law	conce	erning	the p	orivacy	of s	such
information authorizati			to	provid	de ALL	info	rma	tion mar	ked v	with	an as	terisk	(*) m	ay i	nvalida	ate	this

*,	(AKA)	
authorize *(NAME O	E HOCDITAL OR EACH ITV	to disclose health information
obtained in the course of my	diagnosis and treatment for the purpose	of *
•	facility and/or agent? ☐ No ☐ Yes Purpo	
By checking in the spaces to records, if such records exist dates of treatment. I recognize required to keep it confidential	below, I specifically authorize the relet. Such disclosure shall be limited to the fethat if I am disclosing my health information, it may be redisclosed and may no long from redisclosing such information exceptions.	ase of the following medical ollowing types of information or in to someone who is not legally per be protected. California law
Complete medical record(	s) Outpatient Clinic Notes Emergency Report Lab tests	Immunizations Consultation Pathology Other:
INITIAL below for protected of	classes of information:	
Mental Health Treatment	Substance Abuse Treatment	HIV/AIDS Test/Treatment
Sexually Transmitted Dise	ease (City Clinic) Developmental	Disabilities
SEND TO:* (NAME AND ADDRESS O	F HOSPITAL OR FACILITY)	facility is located on back of white copy.
may refuse to sign this authorize writing, signed by me or on my DPH or other facility. My revoce that the DPH may have acted in a copy of this authorization. I eligibility for benefits if I refuse <b>EXPIRATION:</b> Unless otherwise	d that authorizing the disclosure of this hatton. I may revoke this authorization at a behalf by someone with the legal authorization will be effective upon receipt, but w reliance upon this authorization prior to remay not be denied treatment, payment, to sign.  See revoked, this authorization will expire by upon fulfillment for protected classes.	any time. Revocation must be in ty to do so and delivered to the ill not be effective to the extent evocation. I have a right to obtain enrollment in a health plan, or in 90 days, on the following
Date Signature (	Patient/Client/Parent/Guardian/Conservator)	Relationship if not Patient/Client
Witness (Required if Patient/Cl	ient unable to sign)	preter used

## **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 $\square$ APPROVES $\square$ 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.										
		10W 0:								
	Date Physician/Psychologis	visvv signature	Degree							
ACŁ	(NOWLEDGEMENT OF REVIEW OF PHI:									
I,	, ha	e this date reviewed th	ne medical records of the							
patie	ent noted on the reverse at									
	This review has met all my needs and I have n	further requests at th	nis time.							
	This review has NOT met all my needs. I have	ne following further re	quest:							
Sign	ned:	_ Date:								
	San Francisco General Hospital Medical Center Health Information Services, Main Hospital, Room 2B1 1001 Potrero Avenue San Francisco, CA 94110-3518	Health Inform 375 Laguna I	da Hospital & Rehab Center lation Services, Room B300 Honda Boulevard o, CA 94116-1411							
Con	nmunity Health Network Health Center Addresse									
	Castro Mission Health Center 3850 17th Street San Francisco, CA 94114-2031	☐ Ocean Park I 1351 24 <sup>™</sup> Ave San Francisc								
	Chinatown Public Health Center 1490 Mason Street San Francisco, CA 94133-4222	☐ Potrero Hill H 1050 Wiscon San Francisc								
	Cole Street Youth Center 555 Cole Street San Francisco, CA 94117-2800	1525 Silver A	e Family Health Center Avenue o, CA 94134-1229							
	Larkin Street Youth Center 1138 Sutter Street San Francisco, CA 94109-5608	☐ Southeast He 2401 Keith S San Francisco								
	Maxine Hall Health Center 1301 Pierce Street San Francisco, CA 94115-4005	☐ Tom Waddell 50 lvy Street San Francisc								
	Curry Senior Center 333 Turk Street San Francisco, CA 94102-3703	☐ Youth Guidan 375 Woodsid San Francisc								

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient ID / Label

Completion	of this	document	authorizes	the	disclosure	and/or	use of	individua	lly ide	entifiable	health
information,	as set	forth below	, consistent	with	California a	and fede	eral law	concernin	g the	privacy of	of such
information.	Failure	e to provid	de ALL info	orma	tion mark	ed with	an as	terisk (*)	may	invalida	te this
authorizatio	on.	•						. ,	•		
<b> </b> *						/ <b>/ L</b>	۲۸۱				

l*,		(AKA	)
authorize *	(NAME OF HOSPITAL OR FACILITY)		to disclose health information
obtained in the c	,	tment for the purp	oose of *
	sted by DPH facility and/or age		
By checking in records, if such dates of treatmen required to keep requires that recipor as specifically Dates of Treatm  Complete meaning Discharge Second Sec	the spaces below, I specifical records exist. Such disclosure stat. I recognize that if I am disclosing it confidential, it may be redisclosing required by law.  The specific Medical (section of the section of the specific Medical (section of the section of the section of the specific Medical (section of the section of the section of the specific Medical (section of the section of the specific Medical (section of the section of the specific Medical (section of the section of the section of the section of the specific Medical (section of the section of the	Ily authorize the shall be limited to the same and may no such information example.  Condition:  The Clinic Notes  The Clinic Notes	release of the following medical the following types of information or nation to someone who is not legally longer be protected. California law except with my written authorization  Immunizations Consultation Pathology
•	tes X-ray rep		Other:
	or <u>protected classes</u> of informa		
Mental Heal	th Treatment  Substance	Abuse Treatment	HIV/AIDS Test/Treatment
Sexually Tra	ansmitted Disease (City Clinic)	Developme	ntal Disabilities
SEND TO:*			
(NAME	AND ADDRESS OF HOSPITAL OR FACILITY	Address of n	named facility is located on back of white copy.
may refuse to sig writing, signed by DPH or other facithat the DPH may a copy of this au eligibility for bene <b>EXPIRATION:</b> Ur	In this authorization. I may revoke me or on my behalf by someone ility. My revocation will be effection have acted in reliance upon this authorization. I may not be denied fits if I refuse to sign. Inless otherwise revoked, this a	e this authorization e with the legal au ve upon receipt, b authorization prior d treatment, paym uthorization will e	his health information is voluntary. I at any time. Revocation must be in thority to do so and delivered to the ut will not be effective to the extent to revocation. I have a right to obtain ent, enrollment in a health plan, or expire in 90 days, on the following sees. EVENT/CONDITION:
*	* Ciamatura (Dation4/Olion4/D	/Cuandian/Caras	Relationship if not Patient/Client
Date	Signature (Patient/Client/Parent		
Witness (Requ	uired if Patient/Client unable to sign)	u	Interpreter used