SAN FRANCISCO
HEALTH SERVICE SYSTEM
Better Every Day.

EMPLOYEE ASSISTANCE PROGRAM

Authorization to Release Confidential Information

I, (Name of Client): ____
(Print First, Middle Initial, Last)

Hereby authorize **San Francisco Health Service System Employee Assistance Program** to release confidential information obtained during the course of my treatment to (name & function of person or entities to which information is to be relaeased):

____

This authorization permits the release of the following information:

___ Any & all information necessary
___ Diagnosis
___ Progress to Date
___ Patient Records
___ Treatment Plan
___ Prognosis
___ Clinical Test Results
___ Dates of Treatment
___ Summary of Treatment
___ Other (Specify) ________________________

I authorize the release of the information described above for the following purpose(s):

____

____

The recipient may use the information described aboe solely for the following purpose(s):

____

____

I understand that I have a right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be in writing.

This Authorization shall remain valid until: ____________________________ (Expiration Date)

Signed: ____ Date: ____________________
(Client or Client's Representative)