

SAN FRANCISCO HEALTH SERVICE SYSTEM

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO FAMILY MEMBERS

The San Francisco Health Service System (SFHSS) recognizes that spouses, domestic partners, and parents sometimes seek the disclosure of their spouse's, domestic partner's, and non-minor dependent's protected health information for purposes of tracking health claims and resolving claims disputes. SFHSS will not disclose protected health information to such spouses, domestic partners, and parents unless SFHSS has received an authorization from the spouse and/or non-minor dependent whose protected health information is to be disclosed.

By signing below, you are authorizing SFHSS to disclose any of your protected health information held by SFHSS for purposes of treatment, payment and/or operations to other family members identified below. Each adult and non-minor must provide a signature to allow SFHSS to disclose protected health information to a spouse, domestic partner or parent. A signature is also required of a parent of minor dependents that would authorize a step-parent to obtain protected health information on the minor dependent(s). This authorization shall remain in effect until either: (a) the applicable individual is no longer a participant in SFHSS; or (b) SFHSS receives a written revocation of the authorization. Limited information related to claims status and payment history may be disclosed to the employee who is the primary SFHSS enrollee without this authorization, provided that the information does not include any information related to the health services or medical conditions associated with the claim.

This authorization is voluntary and only applies to protected health information related to medical care benefits offered under SFHSS (including health, dental, vision, medical flexible spending, or other coverage affecting any structure of the body). I understand that I may revoke this authorization at any time prior to its expiration date by providing written notification to Marina Coleridge, Privacy Officer, San Francisco Health Service System, 1145 Market Street, 3rd Floor San Francisco, CA 94103, but the revocation will not have any effect on any actions taken in reliance of this authorization or relating to the use or disclosure of the protected health information that SFHSS took before it received the revocation.

I understand that I am not required to sign this authorization to become eligible or to receive my health care benefits (enrollment, treatment, or payment). I understand that the information that is used or disclosed in accordance with this authorization may be redisclosed by the person who receives it and may no longer be protected by federal or state privacy laws.

PRINT YOUR NAME

PHONE NUMBER

Authorize Family Member 1:

I, _____, hereby authorize the use or disclosure of my protected health information to the following family member:

PRINT NAME OF FAMILY MEMBER

RELATIONSHIP

YOUR SIGNATURE

DATE

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO FAMILY MEMBERS

Authorize Family Member 2:

I, _____, hereby authorize the use or disclosure of my protected health information to the following family member:

PRINT NAME OF FAMILY MEMBER

RELATIONSHIP

YOUR SIGNATURE

DATE

Authorize Family Member 3:

I, _____, hereby authorize the use or disclosure of my protected health information to the following family member:

PRINT NAME OF FAMILY MEMBER

RELATIONSHIP

YOUR SIGNATURE

DATE

Authorize Step-Parent:

I, _____, hereby authorize the disclosure of my minor dependent's protected health information to the following step-parent of my minor child(ren):

PRINT NAME OF STEP PARENT

YOUR SIGNATURE

DATE

For further information please contact:
Marina Coleridge, Privacy Officer
San Francisco Health Service System
1145 Market Street, 3rd Floor
San Francisco, CA 94103 | (415) 554-1750

See our Notice of Privacy Practices available online at sfhss.org. A printed copy is also available upon request from the San Francisco Health Service System.