Authorization to Exchange Confidential Information

I, (Name of Client) ____________________________________________

(Print First, Middle Initial, Last)

hereby authorize (Name of Provider): San Francisco Health Service System Employee Assistance Program to exchange confidential information regarding my treatment with (name and function of person(s) or entities to which information is to be exchanged):

_________________________________________________________________________________
_________________________________________________________________________________

This Authorization permits the exchange of the following information:

___ Any and All Information Necessary
___ Diagnosis                  ___ Treatment Plan                  ___ Prognosis
___ Progress to Date           ___ Clinical Test Results          ___ Dates of Treatment
___ Patient Records            ___ Summary of Treatment           ___ Other

_________________________________________________________________________________
_________________________________________________________________________________

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

_________________________________________________________________________________
_________________________________________________________________________________

The recipient may use the information described above 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)

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