SAN FRANCISCO
HEALTH SERVICE SYSTEM

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, hereby authorize the use or disclosure of my protected health information as set forth below.

Entities Authorized to Provide and Receive Information

The San Francisco Health Service System (SFHSS) may use my protected health information for the purpose described below or disclose my protected health information to the entity listed below for the purpose described below:

_____ is/are the person(s)/organization(s) authorized to receive my protected health information from the SFHSS.

Description of Information

Specific description of information to be used or disclosed (including date(s), type of service, claim, etc.):

_____.

Purpose of Use or Disclosure

Specific purpose of the disclosure ("At the request of the individual" is adequate if appropriate):

_____.

Expiration of Authorization

This authorization will expire _____ (indicate date, or an event that relates to you or to the purpose of the use or disclosure). If no expiration date or event is included, this Authorization will expire one year after its execution.

Your Rights

This authorization is voluntary and I understand that I may revoke this authorization at any time prior to its expiration date by notifying, in writing, 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), unless SFHSS asked me to sign this Authorization *prior* to my enrollment and it is for SFHSS' eligibility or enrollment determinations or if it is for SFHSS' underwriting or risk rating determinations.

If SFHSS has requested me to sign this Authorization, I understand that SFHSS must provide me with a copy of this signed Authorization.

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Your Signature or Your Representative's Signature

PRINTED NAME OF SFHSS MEMBER

SFHSS MEMBER SOCIAL SECURITY NUMBER

SFHSS MEMBER ADDRESS

PRINTED NAME OF REPRESENTATIVE (IF APPLICABLE)

RELATIONSHIP TO SFHSS MEMBER

SIGNATURE OF SFHSS MEMBER OR REPRESENTATIVE

DATE

You May Refuse to Sign This Authorization

For further information please contact:
Marina Coleridge, Privacy Officer
San Francisco Health Service System
1145 Market Street, 3rd Floor
San Francisco, CA 94103
(628) 652-4700

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