SAN FRANCISCO
HEALTH SERVICE SYSTEM
Better Every Day.

EMPLOYEE ASSISTANCE PROGRAM

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)