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 (Name of Provider): **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 released):

_____

_____

This Authorization permits the exchange of the following information:

____ Any and All Information Necessary
____ Diagnosis
____ Progress to Date
____ Patient Records
____ Treatment Plan
____ Prognosis
____ Clinical Test Results
____ Summary of Treatment
____ Dates of Treatment
____ Other (Specify)_____

I authorize the release 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)