City and County of San Francisco

Department of Public Health

San Francisco General Hospital and Trauma Center

Sue Currin, Chief Executive Officer

Edwin M. Lee
Mayor

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and federal law concerning the privacy of such information. **Failure to provide ALL information marked with an * may invalidate this authorization.**

I*, _____ AKA _____,

DOB _____ SS# _____ MRN _____

authorize* _____
Name (Physician, Hospital, Clinic, etc.)

_____
Address/City/State/Zip

to disclose health information obtained in the course of my diagnosis and treatment for the purpose of * _____.

By checking in the spaces below, I specifically authorize the release of the following medical records, if such records exist. Such disclosure shall be limited to the following types of information or dates of treatment. I recognize that if I am disclosing my health information to someone who is not legally required to keep it confidential, it may be redisclosed and may no longer be protected. California law requires that recipients refrain from redisclosing such information except with my written authorization or as specifically required by law.

Dates of Treatment AND/OR Specific Medical Condition: _____

☐Complete medical record(s)	☐Outpatient Progress Notes	☐Immunizations
☐Discharge Summary	☐Emergency Room Report	☐Consultation
☐History & Physical	☐Lab tests	☐Pathology
☐Progress Notes	☐X-ray report	☐Other: _____

San Francisco General Hospital and Trauma Center
Occupational Health Service
1001 Potrero Avenue • Bldg. 9 - Rm.115 • San Francisco, CA 94110
Telephone (415) 206-6581 • Fax (415) 206-3669

Initial below for protected classes of information:

____Mental Health Treatment
____HIV/AIDS Treatment
____ Developmental Disabilities
____ Substance Abuse Treatment
____Sexually Transmitted Disease (City Clinic)

SEND TO:

San Francisco General Hospital
Occupational Health Service,
Attention: _____ OR
Building 9, Room 115
1001 Potrero Avenue
San Francisco, CA 94110

☐ Fax (415) 206-3669

Name _____
Address _____
_____
_____
Area Code/Phone Number _____
☐ Fax

☐ Records released to patient.

MY DPH RIGHTS: I understand that authorizing the disclosure of this health information is voluntary. I may refuse to sign this authorization. I may revoke this authorization at any time. Revocation must be in writing, signed by me or on my behalf by someone with the legal authority to do so and delivered to the DPH or other facility. My revocation will be effective upon receipt, but will not be effective to the extent that the DPH may have acted in reliance upon this authorization prior to revocation. I have a right to obtain a copy of this authorization. I may not be denied treatment, payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign.

EXPIRATION: Unless otherwise revoked, this authorization will expire in 90 days, on the following event/condition **OR immediately upon fulfillment** for protected classes:
EVENT/CONDITION: _____

* _____ * _____
(DATE) (Signature of Patient/Client/Parent/Guardian/Conservator)

_____
(Relationship to Patient/Client)

_____
(WITNESS (REQUIRED IF PATIENT UNABLE TO SIGN)

☐ Interpreter used _____

OHS Revised 7/11