San Francisco Department of Public Health
Transgender Health Services
50 Lech Walesa Street
San Francisco, CA 94102
Telephone: (415) 355-7513
Fax: (415) 355-7407
transgenderhealthservices@sfdph.org
www.sfdph.org/transgenderhealthservices

Release of Medical Information

Permission to get records and exchange information

I, _____,with date of birth,_____, am requesting surgery through Transgender Health Services. I understand that my personal information will be reviewed by Transgender Health Services to assist with obtaining treatment and preparing for surgery. I understand that I may need to work with my care team to stabilize my medical conditions, mental health, or substance use before I have surgery.

I give my permission for Transgender Health Services to access any and all medical, mental health, and substance abuse treatment records in the San Francisco Department of Public Health or from my outside providers and clinics, if applicable. This permission that I am giving pertains to my entire history of care with the providers that I list in this document. I also give permission for Transgender Health Services to speak directly with my medical and mental health providers and share surgery-related information with them. I understand that this permission will be used specifically to support my health care needs and determine if surgery is the appropriate next step in my gender transition and what additional support I may need.

Permission to get sensitive information

By putting my initials by each item below, I give permission for records to be sent and information to be communicated containing:

_____ my mental health records
_____my medical records
_____information about transmittable disease I may have like HIV/AIDS
_____genetic records
_____ substance use / substance abuse treatment records

I understand that:

- I do not have to give my permission to share this information. If I do not give permission, I understand it may interfere with or delay my request for referral for surgery.
- If I want to take away the permission for my doctor to get these records, I need to talk to my doctor or a staff person and sign a paper.
- This permission is only valid until all surgical procedures and aftercare are completed, if applicable.
- If I disenroll from the Transgender Surgery Access Program, Transgender Health Services may continue to exchange information with my providers for a limited time to learn how to improve my care in the future and improve outcomes for other patients seeking surgery.

By signing at the end of this document, I also give permission for Transgender Health Services staff to contact me directly.
Phone:_____
Email:_____

Please initial on one of the following lines to indicate your privacy needs:
_____ Transgender Health Services staff can leave confidential information on my voicemail
_____Transgender Health Services staff CANNOT leave confidential information on my voicemail and should instead just leave a call-back number with the staff person's name.

Requesting records from:

(Please list all medical and mental health clinics and substance abuse treatment programs where you have received care in the last 5 years.)

1. Clinic:_____

   Provider/s:_____

   Phone:_____ Dates in Care:_____
2. Clinic:_____

   Provider/s:_____

   Phone:_____ Dates in Care:_____
3. Clinic:_____

   Provider/s:_____

   Phone:_____ Dates in Care:_____
4. Clinic:_____

   Provider/s:_____

   Phone:_____ Dates in Care:_____

   (If you need more space to list more clinics, please attach them on a separate page.)

Types of information we are requesting

Any and all types of records, including:

Doctor visit notes
Emergency Room notes
Urgent care notes
History and physical
Hospital Progress Notes
Operation or procedure notes
Clinic notes
Pathology reports
Doctors orders
Nurses notes
Discharge Summary
Lab reports
Radiology Reports
Consultations
Other _____

Please send records to:

Attention: Transgender Health Services
At fax number: (415) 355-7407
Or mail to: Transgender Health Services
50 Lech Walesa Street
San Francisco, CA 94102

Patient's Signature_____ Date _____

Authorized Representative's Signature_____ Date_____

Relationship of Authorized Representative_____