SAN FRANCISCO
HEALTH SERVICE SYSTEM

Affordable, Quality Benefits & Well-Being

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 Health Service System 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 Health Service System.

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, City & County of 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 the Health Service System 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 the Health Service System asked me to sign this Authorization *prior* to my enrollment and it is for the Health Service System’s eligibility or enrollment determinations or if it is for the Health Service System’s underwriting or risk rating determinations.

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

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Your Signature or Your Representative's Signature

____ _________________________________

PRINTED NAME OF HSS MEMBER HSS MEMBER SOCIAL SECURITY NUMBER

____

HSS MEMBER ADDRESS

____ _________________________________

PRINTED NAME OF REPRESENTATIVE (IF APPLICABLE) RELATIONSHIP TO MEMBER

____ _________________________________

SIGNATURE OF MEMBER OR REPRESENTATIVE DATE

You May Refuse to Sign This Authorization

For further information please contact or consult:
Marina Coleridge, Privacy Officer
City & County of San Francisco
Health Service System
1145 Market Street, 3rd Floor
San Francisco, CA 94103

See our Notice of Privacy Practices available online at myhss.org. A printed copy is also available upon request from the Health Service System.