SAN FRANCISCO HEALTH PLAN
Here for you

SAN FRANCISCO HEALTH AUTHORITY AGREEMENT FORM

San Francisco Health Plan (SFHP) keeps your health information safe and private.

The information SFHP keeps safe can be about your old or new health information. This information can be about your metal health. (This is called protected health information.)

There is a law about sharing health information. The law protects how your information is shared. SFHP can't share information about your health and mental condition unless you agree.

Fill out this form to allow SFHP to share your information. **You need to fill out everything on this form.** If you do not fill out everything, SFHP cannot share information. SFHP follows the law on how to share your information.

WHAT YOU AGREE TO:

- I can decide not to sign this form.
- I can change my mind after I sign this form.

  Here is what to do if you want to stop sharing your health information. If you change your mind, you need to send a letter to SFHP. The letter should have your name and signature on it. The letter should say that you don't want to share your health information.

  Send the letter to:

  San Francisco Health Plan
  To: Compliance Officer
  P.O. Box 194247
  San Francisco, CA 94119
- Nothing will change until SFHP gets this form back. Until SFHP gets this form they will not share my health information.
- I can ask for a copy of this form. If I want a copy of this form, I need to send a letter to SFHP.
- My health care will not change if I do not sign this form.
- If I do not sign this form the rules about sharing health information will be different. If I share my own health information, it is not part of the law. The person I share information with can share the information with another person. Another person cannot share my information unless I agree.
- SFHP will not share my health records without my written agreement. SFHP will not share my Sensitive Services (a visit or treatment that you want to keep private.)
- I do not need approval to get Sensitive Services. I do not need approval to submit a claim for Sensitive Services.

  I need to be the age of an adult and must understand to get Sensitive Services.

  - Sensitive Services can be for mental or behavioral health, sexual and reproductive health, sexually transmitted infections (including HIV and AIDS), alcohol or drug problems, transgender care, and violence from my family or partner.
- I can get a copy of the law that protects my health information. I need to send a letter to SFHP for a copy of the law.
- I know what this form says. I agree to share my health information during the time I am with SFHP.

After you sign this form save a copy for you.

Then mail or fax the form to:

San Francisco Health Plan
Attn: Compliance Officer
P.O. Box 194247
San Francisco, CA 94119
Fax: 1(415) 547-7825

FILL OUT THIS INFORMATION

I agree to share my health information in the way listed below:

Name of who you will allow to share your health information:

San Francisco Health Authority d/b/a San Francisco Health Plan

Name of who gets your health information:

_____

What is the medical reason you need to share your information?

_____

_____

WHAT SAN FRANCISCO HEALTH PLAN CAN SHARE

I allow San Francisco Health Plan to share the below information. (Check only ONE box.)

☐ I agree to share all my health information.

This includes many things about my health. This includes a diagnosis (name of illness or condition), claims, doctors and health care providers, and financial information. This **does not include sensitive (private) information** unless **the boxes are checked below.**

OR

☐ I agree to share only some of my health information. (Check ALL boxes that apply.)

- ☐ Grievances and appeals (legal complaints I make in writing)
- ☐ Benefits and coverage
- ☐ Billing
- ☐ Claims and payment
- ☐ Diagnosis (name of illness or condition) and procedure (treatment)
- ☐ Eligibility and enrollment
- ☐ Financial
- ☐ Medical Records
- ☐ Doctor and Hospital
- ☐ Pre-authorization (treatment approvals)
- ☐ Referral
- ☐ Treatment
- ☐ Pharmacy
- ☐ Other: _____

I also allow San Francisco health Plan to share the private information listed below. (Check ALL boxes that you agree with.)

☐ All sensitive (private) information

OR

☐ Only information about topics checked below:

- ☐ Abortion (ending pregnancy)
- ☐ Abuse (sexual/physical/mental)
- ☐ Alcohol or drug problems
- ☐ Behavioral health
- ☐ Transgender care
- ☐ Genetic testing
- ☐ HIV/AIDs
- ☐ Maternity (pregnancy)
- ☐ Mental Health
- ☐ Sexually Transmitted Illness
- ☐ Other: _____

START AND END DATE OF THIS FORM

(Please write "N/A" if you do not want this form to end on a certain date.)

You can end the agreement listed on this form any time.

The agreement on this form starts on _____ and will end on _____.

YOUR SIGNATURE OR SIGNATURE OF PERSON HELPING YOU

Signature: _____

Date: _____ Time: _____ AM/PM

List the name and relationship of the person if they signed the form for you.

_____