SAN FRANCISCO HEALTH PLAN
Here for you

SAN FRANCISCO HEALTH AUTHORITY STANDARD RELEASE AND AUTHORIZATION FORM

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

Federal law requires San Francisco Health Plan (SFHP) to protect the privacy of information that identifies you and relates to your past, present, and future physical and mental health and conditions ("protected health information").

Completion of this form authorizes the use/disclosure of protected health information, as set forth below, consistent with California and federal law concerning the privacy of such information.

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 your information.

- You do not need to sign this form.
- You can change your mind after signing this form and revoke your authorization.
- If you want to stop sharing your health information, you or your representative must send a letter to SFHP. The letter must be in writing, must have your name, and your signature or authorized representative's 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

- Your revocation will be effective once SFHP receives your revocation request as described above. The revocation will not be effective to the extent that SFHP or others have acted in reliance upon this authorization after the effective date of the authorization and prior to the date of revocation.
- You can ask for a copy of this form. If you want a copy of this form, you need to send a written letter to SFHP.
- Neither treatment, payment, enrollment or eligibility for benefits will be conditioned on your providing or refusing to provide this authorization.
- Information disclosed as a result of this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality laws. However, California law prohibits the person receiving your protected health information from making further disclosure of it unless another authorization for such disclosure is obtained from you or unless such disclosure is specifically required or permitted by law.
- SFHP will not share your medical information about Sensitive Services with anyone without your written agreement.
- You do not need someone else's permission to get Sensitive Services or to submit a claim for Sensitive Services if you have the right to consent. You may need to be a certain age or have sufficient capacity to consent depending on the type of Sensitive Services.

SAN FRANCISCO HEALTH PLAN
Here for you

- 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.

- You may inspect or obtain a copy of the protected health information that will be used or disclosed under this authorization, upon written request to SFHP.
- SFHP's Evidence of Coverage discloses the terms and conditions of coverage.
- By signing this form you agree with this authorization and represent that you understand that this authorization will remain valid during the time you are enrolled with SFHP, with exceptions stated in this form such as the expiration date and your right to revoke the authorization at any time.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize the use/disclosure of my protected health information as follows:

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

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

Name of person/ organization authorized to receive your protected health information:

Reason you want 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 but is not limited to health, 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

SAN FRANCISCO HEALTH PLAN
Here for you

- ☐ 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: _____

SAN FRANCISCO HEALTH PLAN
Here for you

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 standard release and authorization at any time.

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

MEMBER OR PERSONAL REPRESENTATIVE SIGNATURE

Signature: _____

Date: _____ Time: _____ AM/PM

If signed by someone other than the member, list the name and legal relationship to the member.

_____

After you sign this form save a copy for you.

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

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (**1-415-547-7800**) or (**1-800-288-5555**) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been resolved satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

The State Medi-Cal Managed Care "Ombudsman Office" can help you with any questions. You can call them at **1(888) 452-8609.** Hours of Operation are Monday through Friday, 8:00am to 5:00pm PST, excluding holidays.

You can also get help from your doctor, or call SFHP's Customer Service Department at **1(415) 547-7800**, **1(800) 288-5555** (toll-free) or TTY **1(888) 883-7347.** Our office hours are from 8:30am to 5:30pm, Monday through Friday.