SAN FRANCISCO HEALTH PLAN
Here for you

SAN FRANCISCO HEALTH AUTHORITY
STANDARD RELEASE AND AUTHORIZATION FORM

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. **Failure to provide *all* information requested may invalidate this authorization.**

NOTICE OF RIGHTS AND OTHER INFORMATION

- I may refuse to sign this authorization.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the following address:

  San Francisco Health Plan
  Attn: Compliance Officer
  P.O. Box 194247
  San Francisco, CA 94119
- My revocation will be effective upon receipt by SFHP. However, 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.
- I have a right to receive a copy of this authorization upon written request.
- Neither treatment, payment, enrollment or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.
- Information disclosed pursuant to 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 my protected health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.
- I 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.
- I understand and agree that this authorization will continue to be valid as long as I am enrolled with SFHP, subject to all other parameters defined in this authorization, including expiration date and my right to revoke this authorization at any time.

After signing, please make a copy of this authorization for your records and then mail or fax back to:
San Francisco Health Plan
Attn: Compliance Officer
P.O. Box 194247
San Francisco, CA 94119
Fax: 1(415) 547-7825

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

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

Member Demographics:

Name:_____ Birth Date:_____

Address:_____

City, State, Zip:_____ Phone #: _____

Health Plan:_____ ID #: _____

Persons/Organizations authorized to d*isclose* the protected health information:

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

Persons/Organizations authorized to *receive* the protected health information: _____

_____

Purpose of requested use/disclosure: _____

_____

This authorization applies to the following protected health information (select *only* one of the following):

☐ All protected health information pertaining to any medical history, mental or physical condition and treatment received.

☐ All protected health information pertaining to any medical history, mental or physical condition and treatment received, except: _____

_____

☐ Only the following records or types of protected health information (including any dates):

_____

_____

EFFECTIVE DATE AND EXPIRATION

This authorization becomes effective on _____ and will expire on _____.

SIGNATURE OF MEMBER/PERSONAL REPRESENTATIVE

Date: _____ Time: _____ AM/PM

Signature: _____

(Member/Personal Representative)

If signed by someone other than the member, print your name below and your legal relationship to the member:

_____

If you are hearing impaired, please call the TDD/TTY line at **1(415) 547-7830,** toll-free at **1(888) 883-7347** or through the California Relay Service at **711.** You may request this document in alternative formats like Braille, large size print, and audio. To request other formats, or for help with reading this document and other SFHP materials, please call Customer Service at **1(415) 547-7800** or toll-free at **1(800) 288-5555.**