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San Francisco
Health Network
SAN FRANCISCO DEPARTMENT OF
PUBLIC HEALTH

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT INFORMATION

Medical Record # Birth Date: mm / dd / yy Last four digits Social Security Number:

Patient Name: Last First MI

Other Names Used:

Phone: ( ) ☐ Home ☐ Cell ☐ Phone Message Okay Email:

RELEASE MEDICAL RECORDS TO:

Name:

Address:

City State Zip Code

Phone: Fax: Email:

TYPE OF FORMAT (Check one)		TYPE OF DELIVERY (Check one)			
☐ Paper	☐ CD	☐ Mail	☐ Fax	☐ Pick Up	☐ Email (secure)

TREATMENT DATES and LOCATIONS

From: mm / dd / yy to mm / dd / yy

☐ Zuckerberg San Francisco General Hospital and Trauma Center		☐ Laguna Honda Hospital and Rehab Center	
☐ Balboa Teen Health Center	☐ Behavioral Health Services 1380 Howard Street	☐ Ocean Park Health Center	☐ Southeast Health Center
☐ Castro Mission Health Center	☐ Curry Senior Center	☐ Potrero Hill Health Center	☐ Tom Waddell Urban Health Center (230 Golden Gate Avenue)
☐ Chinatown Public Health Center	☐ Larkin Street Youth Center	☐ S.F. Behavioral Health Center 887 Potrero Avenue	☐ Tom Waddell Urgent Care (50 Dr Tom Waddell Place)
☐ Cole Street Youth Center	☐ Maxine Hall Center	☐ Silver Avenue Health Center	☐ Youth Guidance Center

☐ Other Location:

PURPOSE OF REQUEST (45 CFR 164.508)

☐ Personal Use (Copies)	☐ Healthcare Provider	☐ Legal Purpose
☐ Disability Claim	☐ Insurance	☐ In-Person Review of Records

☐ Other (please specify):

PLEASE CHECK ITEMS TO BE RELEASED

☐ Pertinent Packet: Discharge Summary, Operative Report, Lab, X-ray, Consultation, Pathology

☐ Discharge Summary	☐ Emergency Room Record	☐ EKG/ Echo
☐ History & Physical Exam	☐ X-Ray/ CT/ MRI/ ULT/ NM	☐ Immunizations
☐ Consultation Report(s)	☐ Progress Note(s)	☐ Lab
☐ Operative Report(s)	☐ Complete Health Record	☐ Dental
☐ Anesthesia Record	☐ Implant Record	☐ Other:
☐ Pathology Report(s)	☐ Substance Use Disorder Treatment Records**	☐ Mental Health Records**

**SPECIAL AUTHORIZATIONS - Requires additional signatures and dates below.

Substance Use Disorder Treatment Records	Signature	Date mm/dd/yy
Mental Health Treatment	Signature	Date mm/dd/yy
HIV Test	Signature	Date mm/dd/yy
Genetic Testing	Signature	Date mm/dd/yy

REQUESTING YOUR HEALTH RECORDS

Completing the request form

- Complete all information. Note: Incomplete information delays the release of records.
- List all names you have used when receiving medical services.
- Be specific about the records you want. Under "Special Instructions," you may also indicate the specific documents you do NOT want released. (Example: Records from _____ visit).
- Please complete one form for each location where you want your records sent.

Cost

- Note: Copies released to another healthcare provider are provided without charge.
- There may be a fee for medical records due at the time of your pick-up.
- If you request ALL records, the cost per volume of records may exceed $50.00.
- Attorneys or insurance companies who are authorized to receive your records may be responsible for applicable fees.
- Other departments, such as Radiology and Billing, may have additional charges.

When will my records be ready?

- Requests for records release are usually processed within 5-10 business days, excluding holidays & weekends.
- Complete requested format and delivery: Paper, CD, Secure email, Mail, Fax, Pick-Up.
- You will be contacted when your records are ready for pick-up.
- Valid Picture Identification is required to pick-up or review your records.

Reviewing your records

- Complete the records release form and check the "In-person Review of Records" option. Note: Only those records you requested will be available during your review session.
- A representative will contact you to make an appointment within 5 business days. Your appointment will be scheduled during normal business hours.
- For current in-house SNF residents, a representative will contact you to review your health records within 24 hours.
- Please bring valid picture identification with signature.
- One person may accompany you. His/her name must be included on the authorization form.
- You will have approximately 1 hour to review your record. A staff member will be present during your review; however, they will not be able to answer any medical questions or interpret the documents. The fee for reviewing records is $15.00 and must be reviewed in the department.

COMMON DOCUMENTS in a Medical Record

SPECIFIC RECORDS may include	ALL RECORDS would also include:
• HISTORY AND PHYSICAL • DISCHARGE SUMMARY (Inpatient) • PATHOLOGY • DIAGNOSTICS (X-rays, CT, MRI, Nuclear Medicine, & Ultrasounds • LABS (Blood Test, Urine Test, etc...) • PROGRESS NOTES (Inpatient) • CLINIC NOTES (Outpatient) • THERAPY (Physical, Occupational, Speech) • MAJOR DIAGNOSTIC TEST (Echocardiograms, EEG, Stress Test, Colonoscopy, etc.) • Cardiology Exams • OPERATIVE REPORTS	Specific Records PLUS: • DOCTORS ORDERS (Inpatient) • NURSING NOTES AND RELATED DOCUMENTS (Inpatient) • MEDICATION ADMINISTRATION RECORDS (Inpatient) *All Records are from first date of service to current date.* ** Special Authorizations section on page 1 Requires additional signature and date for the special services listed.

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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

SPECIAL INSTRUCTIONS: Indicate below any limitation to the records requested (dates, treatment)

TIME LIMIT and RIGHT TO CANCEL

This authorization to release health information is voluntary and may be canceled at any time. Unless canceled, this authorization will expire on the following date mm/dd/yy, or one year from date of signature, unless otherwise specified. The cancellation must be in writing, signed by you or your representative and delivered to medical records of the facility where requested. The cancellation will take effect upon receipt of your signed cancellation, but will not apply to records already sent.

REDISCLOSURE/ RE-RELEASE

I understand the information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA); however, information protected by 42 CFR Part 2 continues to be subject to that protection. In addition, California law prohibits the person receiving my 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. The facility is hereby released from any legal responsibility or liability for disclosure of information to the extent indicated and authorized.

MY RIGHTS

I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment, payment, or eligibility of benefits. I may inspect or obtain a copy of the health information I am being asked to disclose.

COPY I understand that I have the right to a copy of this authorization.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE WHO MAY REQUEST DISCLOSURE

I authorize San Francisco Department of Public Health/ Medical Records to disclose the protected health information specified above.

Patient/Representative Signature: _____ Date: mm/dd/yy

Print Name: _____

If not the patient, indicate Relationship: ☐ Parent ☐ Guardian ☐ Executor ☐ Other: _____

Witness: _____
(Required if Patient/Client unable to sign)

HIS Staff Only:

ID Verification: ☐ Drivers License ☐ Passport ☐ Other _____

Verified By: _____ / mm/dd/yy
Initials and Date

Request Received By: _____ / mm/dd/yy
Initials and Date

Request Processed By: _____ / mm/dd/yy
Initials and Date

Requested Copies Provided on mm/dd/yy via ☐ Mail ☐ Fax ☐ Pick Up ☐ Other _____

****MENTAL HEALTH RECORDS (Lanterman-Petris-Short Act)**

Undersigned physician, licensed psychologist or social worker in charge of mental health care of this client

☐ APPROVES release of the mental health treatment records. ☐ AGREES to provide a summary of the mental health record.

☐ DENIED by clinician - Reason: _____

☐ Other: _____

Mental Health Provider	**Degree**
Date: mm/dd/yy Signature _____ CHN ID# _____	
Printed Name/ designation _____	

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SAN FRANCISCO HEALTH NETWORK HOSPITALS

Zuckerberg San Francisco General Hospital and Trauma Center
1001 Potrero Avenue
San Francisco, CA 94110-3518

Laguna Honda Hospital and Rehab Center
375 Laguna Honda Blvd
San Francisco, CA 94116-1411

SAN FRANCISCO HEALTH NETWORK HEALTH CENTER ADDRESSES

Balboa Teen Health Center
1000 Cayuga Avenue
San Francisco, CA 94112

Castro Mission Health Center
3850 17th Street
San Francisco, CA 94114-2031

Chinatown Public Health Center
1490 Mason Street
San Francisco, CA 94133-4222

Cole Street Youth Center
555 Cole Street
San Francisco, CA 94117-2800

Behavioral Health Services
1380 Howard Street
San Francisco, CA 94103

Curry Senior Center
333 Turk Street
San Francisco, CA 94102-3703

Larkin Street Youth Center
1138 Sutter Street
San Francisco, CA 94109-5608

Maxine Hall Health Center
1301 Pierce Street
San Francisco, CA 94115-4005

Ocean Park Health Center
1351 24th Avenue
San Francisco, CA 94122-1616

Potrero Hill Health Center
1050 Wisconsin Street
San Francisco, CA 94107-3328

San Francisco Behavioral Health Center
887 Potrero Avenue
San Francisco, CA 94110

Silver Avenue Family Health Center
1525 Silver Avenue
San Francisco, CA 94134-1229

Southeast Health Center
401 Keith Street
San Francisco, CA 94124-3231

Tom Waddell Urban Health Center
230 Golden Gate Avenue
San Francisco, CA 94102-3706

Tom Waddell Urgent Care
50 Dr Tom Waddell Place
San Francisco, CA 94102

Youth Guidance Center
375 Woodside Avenue
San Francisco, CA 94127-1221

NOTE: Requests for records can be sent directly to the location of your choice.

How do I request my records? ∘ Complete the records release form and return to the appropriate department

Medical Records *Medical documentation from the hospital or clinics*	Zuckerberg San Francisco General Hospital 1001 Potrero Avenue, Bldg 5, 2nd Floor, 2B1 San Francisco, CA 94110-3518	Monday - Friday 8 am - 4:00 pm Closed weekends and holidays 628-206-8640 Fax: 628-206-8623
	Laguna Honda Hospital and Rehab Center 375 Laguna Honda Blvd 3rd Fl., B-300 San Francisco, CA 94116-2411	Monday - Friday 8 am - 4:00 pm Closed weekends and holidays 415-759-3355 Fax: 415-759-2373
Diagnostic Images *(e.g. X-rays, CT Scans)*	ZSFG Imaging Library 1001 Potrero Avenue, Room 1X42 San Francisco, CA 94110-3518	Monday-Friday 8:30 am - 4:30 pm 628-206-8033 Fax: 628-206-8946
Mental Health Records	Behavioral Health Services 1380 Howard Street San Francisco, CA 94103	415-255-3487 Fax: 415-252-3001
	San Francisco Behavioral Health Center 887 Potrero Avenue San Francisco, CA 94110	628-206-6314 Fax: 628-206-6316
Billing (Hospital)	ZSFG Billing Department 1001 Potrero Avenue, Bldg 20, 4th Floor San Francisco, CA 94110	Monday -Friday 8:00 am-5:00 pm (Closed 12 noon - 1:00 pm) 628-206-8448 Fax: 628-206-4613

Note: Requests from multiple locations may be sent separately