T-RI0002

San Francisco
Health Network
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION OR VERBAL CARE COORDINATION

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:

☐ REQUEST RECORDS FROM:

☐ 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	☐ MYCHART

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	
☐ SF Ambulatory / Specialty Clinics	☐ SF Youth Teen Center	☐ Jail Health
☐ Behavioral Health Centers	☐ Curry Senior Health Center	☐ Home Health
☐ Other:		

PURPOSE OF REQUEST (45 CFR 164.508)

☐ Personal Use (Copies)	☐ Healthcare Provider	☐ Legal Purpose
☐ Disability Claim	☐ Insurance	☐ In-Person Review of Records
☐ Verbal communication with those listed above	☐ Other (please specify):	

BEHAVIORAL HEALTH FINANCIAL ELIGIBILITY AUTHORIZATION

☐ Subscriber Assignment of Benefits ☐ Subscriber Release of Info ☐ Coordination of Benefits

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	☐ Billing Statements/Records
☐ Pathology Report(s)	☐ Substance Use Disorder Treatment Records**	☐ Mental Health Records**
☐ Other:		

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

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

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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 SFDPH and SF Health Network to disclose protected health information 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 Request Processed By: _____ / mm/dd/yy
Initials and Date Initials and Date

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

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

Undersigned licensed or waivered mental health provider in chart of the mental health care of the 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 CENTERS

This is NOT a complete list – write other location on your request

- Adult Immunization & Travel Clinic (AITC)
- Balboa Teen Health Center
- Breast & Cervical Cancer Services
- Castro-Mission Health Center
- Children's Health Center at ZSFGH
- Chinatown Public Health Center
- Cole Street Clinic
- Curry Senior Center
- Family Health Center at ZSFGH
- Richard Fines People Clinic
- Hawkins Village Teen Health Center
- Hip Hop Health Clinic
- Larkin Street Medical Clinic
- Maria X Martinez Health Clinic
- Maxine Hall Health Center
- Ocean Park Health Center
- Potrero Hill Health Center
- Silver Avenue Family Health Center
- Southeast Family Health Center
- Special Programs for Youth
- City Clinic on 7th Street
- Tom Waddell Health Center
- Transgender Health Clinic
- Women's Health Center
- Central City Behavioral Health Services
- Chinatown Child Development Center
- Chinatown North Beach Mental Health Services
- Community Justice Center
- Comprehensive Crisis Services
- CYF Psychological Assessment Services
- Drug Court Treatment Center
- Educationally Related MHS (AB3632)
- Family Mosaic Project
- Foster Care Mental Health Program
- Law Enforcement Assisted Diversion (LEAD)
- Mission Family Center
- Mission Mental Health Team I
- OMI Anchor Program
- OMI Family Center
- SF Fully Integrated Recovery Services Team (FIRST)
- South of Market MHS
- South Van Ness HIV and Gender Services
- Southeast Child and Family Therapy 1
- Southeast Child and Family Therapy Center 2
- Southeast Mission Geriatric Services
- Sunset Mental Health Services Adult
- Transitional Age Youth Service
- Health at Home

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
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
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

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.

Verbal Communication Authorization

- Coordination of medical services where special authorization is required: Mental Health, Substance Use Disorder, HIV test results where both verbal AND written authorization is needed

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.