San Francisco
Department of Public Health

Written consent forms for BEAM Telehealth and Navigation program for Medications for Opioid Use Disorder

What are these forms?

There are three different forms:

- Consent to Treatment: This form indicates that you consent to receive treatment services.
- HIPAA: This form indicates that you are informed on how medical information about you may be used and shared by the San Francisco Department of Public Health (SFDPH) and how you can get your information.
- SUD Universal Consent: This form indicates that you are giving permission for SFDPH providers to document and access information related to substance use (drug and alcohol use) treatment.

Why am I signing them?

We want to ensure you agree and consent to receiving treatment and understand your rights. They are important forms for you to review and sign to indicate your awareness of how your medical information will be used and shared within SFDPH to provide you with the safest and best care. If you have questions about the content or purpose of these forms, please ask the BEAM Navigator, BEAM Telehealth Provider or reach out to telemoud@sfdph.org.

What do I do after I sign these forms?

You can return these forms in two ways:

1) By fax using the attached coversheet
2) By secure email to telemoud@sfdph.org with “Secure: Consents” in the subject line

San Francisco
Department of Public Health

Medical Facsimile Cover Sheet

TO:

Name:	Remi Franklin BEAM Telehealth and Navigation for Medications Administrative Coordinator
Phone	628-754-9154
Fax:	628-754-9581

FROM:

Name:	
Signature:	
Phone:	
Fax:	
Date:	

CONFIDENTIAL

Confidential Health Information Enclosed. This protective cover sheet is in compliance with the Health Insurance Portability and Accountability Act (HIPAA). As health information is personal and sensitive, you the recipient are obligated to protect the confidentiality of this transmission. This transmission has been sent after obtaining authorization from the individual or under conditions where the individual's authorization was not required. Law prohibits re-disclosure of these documents without obtaining additional consent or authorization by the individual. **Unauthorized redisclosure of these documents or failure to keep these documents safe, confidential, and secure can subject you to penalties under Federal and/or State Law.**

This facsimile transmission is intended for the sole confidential use of the designated recipients, some or all of which may be protected health information as defined by the federal Health Insurance Portability & Accountability Act (HIPAA) Privacy Rule. If you have received this information in error, any review dissemination, distribution, or copying of this information is strictly prohibited. If you have received this transmission in error, please contact the sender to arrange for the destruction or return of the information. If any pages failed to send, please contact the sender at the above number.

I. GENERAL CONSENT

A. **Consent to Clinical, Medical Services and Surgical Treatment**: I consent to the treatment which may occur during the encounter. These may include, but are not limited to, clinical encounters, behavioral health services, Health at Home/Home Health Services, emergency treatment or services, laboratory procedures, X-ray examinations, medical or surgical treatment or procedures, care facilitated by telecommunication technologies ("telehealth"), anesthesia, or hospital services provided to me under the general and special instruction of a provider or surgeon. I understand that the practice of clinical and behavioral health medicine and surgery is not an exact science, and that diagnosis and treatment may involve risks of injury or even death. I acknowledge that no guarantees have been made to me regarding the result of examination or treatment.
Maternity Patients: If I deliver an infant(s) while a patient of this hospital, I agree that these same conditions of admissions apply to the infant(s).

B. **Photography/Videotaping**: I consent to the taking of pictures, videotapes and recordings necessary for identification purposes, to document processes of diagnosis and treatment and to document injuries sustained in trauma. I further consent to the use of such pictures, videotapes and recordings for provision of care, quality improvement, education, and reimbursement purposes. (there may be exceptions for Behavioral Health Services)

C. **Teaching, Research and Healthcare Institution:** San Francisco Department of Public Health Programs, Clinics, Zuckerberg San Francisco General Hospital, Laguna Honda Hospital and affiliated programs are a teaching, research and healthcare institution. I understand that residents, interns, medical students, students of ancillary health care professions (e.g., nursing, x-ray, rehabilitation therapy), post-graduate fellows, and other trainees and visiting professors may observe, examine, treat, and participate at the request and under the supervision of the attending providers/physicians in my care. I also understand that an institutional review board approves projects conducted by the researchers in accordance with state and federal law. As a result, I understand that I may be contacted and asked to participate in research studies, but I am under no obligation to do so. My decision whether to participate or not will not affect my ability to obtain medical care.

D. **Use of Medical Information and Specimens for Reporting**: I understand that my medical information, photographs, and/or video in any form may be used for other SF Department of Public Health (SFDPH)/SF Health Network (SFHN) purposes, such as quality improvement, patient safety, and education. I also understand that my medical information and tissue, fluids, cells and other specimens (collectively, "Specimens") that the SFDPH/SFHN may collect during the course of my treatment and care may be used and shared with researchers and any such use will be consistent with

state and federal law, including all laws and regulations governing patient confidentiality, as written in the Notice of Privacy Practice. I understand that under California law, I do not have any rights to any commercially useful products that may be developed from such research.

I understand that if I am diagnosed with a reportable disease in California, including but not limited to cancer, HIV, sexually transmitted diseases, seizures, tuberculosis, viral meningitis, or other reportable diagnoses, DPH is required by law to report my diagnosis to governmental organizations such as the State Department of Health Services or the Center for Disease Control and Prevention. Suspected child abuse, elder abuse and those who may be a harm to themselves, or others are required by law to be reported to protective services. SFDPH also reports immunizations and TB tests to the California Immunization Registry as required by law. If you do not want this immunization information shared with other providers, you can contact the CAIR registry cairweb.org or help desk 1-800-578-1889

E. **Medication History**: I consent that SFDPH/SFHN may electronically access my medication history from external pharmacies and record this information in my medical record unless I provide SFDPH with timely written notice of my objection. I understand that the SFDPH/SFHN may use software to search the computer databases of external pharmacies and pharmacy benefit managers for purposes of obtaining my medication history and making decision regarding my care.

F. **Body Substance Precautions:** I understand that SFDPH/SFHN health care workers are required to follow strict Body Substance Precautions in all patient/client/resident care activities to protect both patients/clients/residents and staff from infections. Therefore, health care workers are not required to be tested for bloodborne pathogens.

G. **E-mail and Texting Consent**: I consent to having appointment reminders sent to me via texting/email or MyChart notification with the understanding that I may **opt out** at any time. I understand that if I email or text providers and others involved in my care that they may not be able to respond to me using the same method I used, due to protected confidential information. I understand that texting and email by either sender may not be secure communication methods as unencrypted messages could be intercepted.

H. **Health Information Exchange**: I understand my information will be available in a secure network such as Epic CareEverywhere, unless I **OPT-OUT**. This exchange allows authorized health care providers/organizations and professionals involved in my treatment, coordination of care, quality improvement, and activities related to management or payment, access to my health care records to provide me with the most informed and quality healthcare.

I. **Care Coordination**: I consent to the disclosure and use of my health information by providers within SFDPH/SFHN and between SFDPH/SFHN, its affiliates and contract providers for the

purposes of care coordination. The health information shared may include but is not limited to: medical, surgical, allergies, dental, vision, hearing, nutrition, tobacco cessation, lab work, development, and mental health that may be necessary for my treatment.

J. **Privacy - Social Security Number**: Pursuant to the Federal Privacy Act of 1974, you are hereby notified that if you have a social security number, disclosure of your social security number is mandatory. It is used to verify your identity in the medical care, and payment system. Disclosure of the social security number is required pursuant to regulation 4, Section 404.1256, Code of Federal Regulations, under Section 218, Title II, of the Social Security Act, as amended.

II STANDARDS OF CONDUCT

A. **SFDPH/SFHN Policies:** I agree to abide by all SFDPH/SFHN policies regarding my conduct on SFDPH/SFHN premises or in the presence of DPH Staff.

B. **Smoke Free Environment:** I acknowledge that SFDPH/SFHN is a smoke free environment and agree not to smoke inside any of its buildings or on SFDPH/SFHN premises or in the presence of DPH Staff.

C. **Safe Environment for Patient Care: No Alcoholic Beverages, Illegal Drugs, or Fire Arms**: I agree not to bring alcoholic beverages, illegal drugs, firearms or other dangerous weapons onto SFDPH/SFHN premises or in the presence of DPH Staff. I agree that my personal belongings may be searched by properly authorized personnel of SFDPH/SFHN, the San Francisco Police Department or the San Francisco Sheriff's Department.

III. FINANCIAL TERMS

A. **Agreement to Reimburse SFDPH/SFHN:** I agree to pay the full costs of health care services provided by applicable federal and state laws, ordinances, resolutions, and orders of the City and County of San Francisco including, but not limited to, San Francisco Municipal Code Part Ill, Chapter V. Article 3 (Health Code). I agree to permit SFDPH/SFHN to investigate and verify any personal and/or financial information submitted in support of my request for services and any application for public entitlement benefits. I hereby freely and voluntarily waive the statute of limitation of SFDPH/SFHN's right to assert a lien against my property or any action in the courts of the State of California to collect the costs of services such as hospital care, outpatient services and professional services. I understand that I will receive messages and calls on behalf of SFDPH/SFHN, at the numbers provided, including my cell phone number and e-mail address provided during my registration process. Methods of contact may include using pre-recorded/ artificial voice messages and/or use of an automatic dialing device, as applicable. I authorize SFDPH/SFHN to execute all refunds resulting from any charges incurred by me or persons for

whom I am the responsible party.

B. **Relationship Between SFDPH/SFHN and UCSF Providers**: I understand that the providers, physicians and surgeons, in both the inpatient, outpatient setting (inclusive of behavioral health) and radiologists, pathologists, emergency providers, anesthesiologists, and others, are not employees or agents of the hospital or SFDPH/SFHN. These providers may bill separately for professional services under the business name the San Francisco Medical Group.
Medical doctors (MD, DO) are licensed and regulated by the Medical Board of California. To check up on a license or to file a complaint go to www.mbc.ca.gov, email: licensecheck@rnbc.ca.gov

C. **Agreement to Reimburse San Francisco Medical Group**: I agree that in consideration of the services provided by any providers, physician, surgeon or dentist that I will pay the regular rates for all professional fees for which I am liable. I agree to permit the San Francisco Medical Group to investigate and verify any personal and financial information submitted in support of the request for services and for any application for public entitlement benefits. I hereby freely and voluntarily waive the statute of limitation of the San Francisco Medical Group's right to assert a lien against my property or commence in any action in the courts of the State of California to collect the costs of professional services.

The Open Payments database is a federal tool used to search payments made by drug and device companies to providers and teaching hospitals. It can be found at https://openpaymentsdatacms.gov

D. **Release of Information for Reimbursement**: I agree that, to the extent necessary to determine liability for payment and to obtain reimbursement, SFDPH/SFHN may disclose portions of my medical record to any person or corporation which is, or may be, liable for all or any portion of SFDPH/SFHN's charges, including, but not limited to, insurance companies, insurance carrier's review organizations, health care service plans, or workers' compensation carriers. I understand that my medical record may be reviewed by a contractor or representative of such a person or corporation. I also understand that in order for me to prevent the release of my medical record for reimbursement purposes, I must provide SFDPH/SFHN with timely written notice.

E. **Assignment of Benefits**: I assign and authorize direct payment to SFDPH/SFHN and the San Francisco Medical Group for all insurance benefits payable for outpatient, clinic, behavioral health or hospitalization. I agree that the insurance company's payment pursuant to this authorization shall discharge the insurance company's obligation to the extent of such payment. I understand that I am financially responsible for charges not paid according

to this assignment.

F. **Medi-Cal/Medicare Parts A & B**: I certify that any information given in applying for benefits of the MEDI-CAL or MEDICARE programs is correct. I authorize release of any information necessary to act on this application. I request that payment of any benefits be made on my behalf to SFDPH/SFHN and the San Francisco Medical Group and agree to pay any remaining charges for which I am legally responsible.

G. **Authorized Representative**: I authorize SFDPH/SFHN, at its election but without obligation, to represent me regarding any application and appeal for eligibility and benefits related to Medicare, MEDICAL, California Children Services, Victims of Crimes, or other programs providing benefits relating to services rendered at a SFDPH/SFHN facility.

H. **Lien Against Third Parties**: In the event that I file a cause of action in a court or assert a claim against another party alleging that any part of the outpatient services or hospitalization were necessitated by the wrongful conduct of another, I agree to give notice of such case to the Bureau of Delinquent Revenue Collection in the Tax Collector Office as provided in San Francisco Health Code Section 124.5 to facilitate enforcement of the cost reimbursement lien established by San Francisco Health Code Section 124. I acknowledge that the cost of service under the circumstances stated herein is a lien upon any damages recovered by me, whether by judgment, settlement, or compromise.

I. **Health Plan Obligation**: SFDPH/SFHN maintains a list of health care service plans with which it contracts. A list of such plans is available upon request from the financial office. SFDPH/SFHN has no contract, express or implied, with any plan that does not appear on the list. I agree to pay the full charges of all services rendered to me by SFDPH/SFHN if I belong to a plan that does not appear on the above-mentioned list. Providers, physicians and surgeons may bill separately for their services. It is my responsibility to determine if provider/physicians providing services to me contract with my health plan, if any.

J. **Health Coverage, Charity Care and Discount Payment Program Assistance**: The SFDPH/SFHN provides health coverage application assistance to uninsured and underinsured clients/ residents/patients to help cover the cost of services. Clients, Residents, Patients may be eligible for programs that include: (1) Medi-Cal, which provides free or low-cost health insurance to eligible California residents with limited income, (2) Presumptive Eligibility Medi-Cal, which provides immediate access to temporary, no-cost Medi-Cal services while individuals apply for permanent Medi-Cal, (3) Healthy San Francisco, an affordable health care access program for San Francisco residents, (4) San Francisco County Sliding Scale

Program, the county medical assistance program for San Francisco residents, and (5) Covered CA, which is the state's health insurance marketplace where California residents can shop for health plans and access financial help. Application assistance for these programs is available by contacting the Patient Access Enrollment Office at (628) 206-7800. The San Francisco Health Network (SFHN) also offers Charity Care and Discount Payment programs to clients, residents, patients who cannot afford the cost of services and who have cooperated with providing or pursuing all third-party coverage. The Charity Care and Discount Payment policy is located on the Zuckerberg San Francisco General Hospital website at https://zuckerbergsanfranciscogeneral.org/ for full eligibility requirements. Application assistance is available by contacting the Patient Financial Service Office at (628) 206-3275 or through the MyChart patient portal. The Health Consumer Alliance (https://healthconsumer.org/) provides health coverage assistance. Bay Area Legal Aid (https://baylegal.org/) provides health consumer and legal assistance. There are other organizations that will help clients, residents, patients understand the billing and payment process. The chargemaster of shoppable services (which is a listing of items that could be billed to a client, resident, patient) is located on the State of California Department of Health Care Access Information (HCAI) website at https://hcai.cagov/.

IV. TERMS FOR INPATIENTS ONLY

A. **Provider Orders:** I agree that medical treatments administered in the hospital will be limited to those prescribed by a provider or surgeon who is a member of the hospital Medical Staff.

B. **Nursing Care:** The hospital provides only general nursing care and care ordered by the physician/provider members of the medical staff. If I want a private duty nurse, I agree to make such arrangements. The hospital is not responsible for failure to provide a private duty nurse and is hereby released from any and all liability arising from the fact that the hospital does not provide this additional care.

C. **Remain On Nursing Unit:** I agree to remain in the unit/hospital. I understand that if I make the choice to leave the unit/hospital unaccompanied by hospital staff, without the permission of nursing staff or physician orders, that I may be discharged from the hospital.

D. **Personal Valuables**: Hospital liability for loss of any personal property deposited with the hospital for safekeeping is limited by law to five hundred dollars ($500.00) unless I receive a written receipt for a greater amount from the hospital. Clothing and other personal items will be discarded if not claimed within thirty (30) days of discharge from the hospital.

CERTIFICATION

I hereby certify that I have read the foregoing and received a copy. I am the client, patient, resident, or legal representative, or am otherwise duly authorized by the individual to sign the above and accept its terms on his/her behalf.

Date: Time:

Client/Patient/Resident Signature:

Client/Patient/Resident Printed Name:

Client, Patient or legal Representative Signature:

Client, Patient or legal Representative Printed Name:

[ ] Refused to Sign [ ] Physically Unable to Sign

If signed by someone other than the client/resident/patient, indicate

Relationship:	Date of Birth:	
Witness Signature:	Printed Name:	Date/Time:
Witness Signature:	Printed Name:	Date/Time:
Interpreter Language: Interpreter ID #	Signature if present:	

Advance Directives: SFDPH/SFHN honors client/resident/patients' wishes regarding treatment decisions whenever possible. SFDPH/SFHN encourages individuals to communicate their health care preferences to their health care providers and to those who may have to make health care decisions for them if they become incapacitated. SFDPH/SFHN does not discriminate against an individual based on whether the individual has executed an Advance Directive. If an Advance Directive has been executed, the undersigned is responsible for providing a copy of the Advance Directive to SFDPH/SFHN for inclusion in the medical record.

Do you have an Advance Directive for Health Care? ❑Yes ❑No

- ☐ I have been informed that it is my responsibility to present this Directive to the SFDPH/SFHN as a permanent part of the chart.
- ☐ I have received information on Advance Directives.
- ☐ I decline to receive information on Advance Directives at this time.

UPON REQUEST, A COPY OF THIS DOCUMENT WILL BE GIVEN TO THE CLIENT, PATIENT, RESIDENT OR ANYONE SIGNING THIS DOCUMENT.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND SHARED BY THE SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH (DPH) AND HOW YOU CAN GET YOUR INFORMATION. PLEASE LOOK IT OVER CAREFULLY.

If you have any questions about this Notice, please call the toll-free Privacy Hotline at 1-855-729-6040.

WHO WILL FOLLOW THIS NOTICE:

The San Francisco Department of Public Health (DPH) Notice applies to the following:
- Anyone who is allowed to enter information into your DPH health record.
- All departments and units of DPH, DPH affiliates, and DPH contract providers/business associates who are allowed to read, use or give out patients' personal health information.
- Members of volunteer groups who help you while you are receiving care from DPH.
- DPH health workers and University of California at San Francisco employees who work with DPH.
- Persons going to school to be a healthcare worker and their teachers who help give your health care in DPH, for example medical residents, medical students, nursing students, fellows or graduate students.

DPH PLEDGE ABOUT HEALTH INFORMATION:

At the San Francisco Department of Public Health we know that health information about you and your health is personal. We promise to protect your health information. We create a record of care and services you receive at DPH. This record is needed to give you quality health care and to meet California and federal law. This Notice applies to all records of your care kept by DPH.

DPH records and stores patient information on paper and in computers.. Health care workers, nurses and doctors share this information with one another in order to care for your health.

The law requires DPH to:
- Keep a record of the care it provides you;
- Make sure that health information that could be used to identify you is kept private (with certain exceptions);
- Comply with the Genetic Information Nondiscrimination Act (GINA) to avoid the use or disclosure of genetic information for discrimination or underwriting purposes;
- Give you this Notice of DPH legal duties and privacy practices;
- Follow the Notice that is in effect at this time; and
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU:

In general, you have the following rights regarding health information kept by DPH about you:

- **Right to Ask to Inspect and Copy.** You have the right to ask to see, read, and obtain a copy of health information used to make decisions about your care. This includes medical and billing records. If you want to look at and obtain a copy of health information used to make decisions about your care, you must send, or deliver during regular business hours, your request in writing to the medical records office at the location your care was given (see the end of this Notice for a list of addresses). If you ask for a copy of the information, DPH may ask you to pay for copying, mailing or getting other supplies needed to respond to your request.
- **Right to Authorize Sharing of Health Information.** You have the right to ask DPH to send copies of your health information to whomever you wish – your family, close friends, or others involved in your care; other individuals, health care providers. You may ask DPH to stop your requested sharing of your health information at any time. To ask DPH to share your health information with people you designate, you must ask in writing. Send or take your request to the medical records office at the site where your care was given (see the end of this Notice for a list of addresses).
- **Right to Request Changes.** If you believe that health information stored by DPH about you is not correct or not complete, you have the right to ask DPH to change the information, or to write an addendum to be included in your health record. You have the right to ask DPH to change your health information for as long as the information is kept. To ask for a change, send your request in writing to the medical records office of the site where your care was given (see the end of this Notice for a list of addresses). In addition, you must explain why you want your health information changed. DPH may say "no" to your request if it is not in writing or does not explain why you want the information changed. In addition, DPH may turn down your request if you ask to change information that:
  - Was not created by DPH health workers;
  - Was recorded by a person who is no longer available to make the change;
  - Is not part of the health information kept by or for DPH;
  - Is not part of the information that you would be allowed to look at and copy; or
  - Is found to be correct and complete.

  We must tell you why we are not making the change within 60 days of your request. You have the right to submit a written addendum (supplement) not to exceed 250 words regarding any item or statement in your record you believe is incomplete or incorrect. If you tell us in writing that you want the supplement to be added to your medical records, we will attach it to your records.
- **Right to an Accounting of Disclosures.** As of April 14, 2003, you have the right to be informed about the times that we have shared your health information. This "Accounting of Disclosures" is a list of persons outside DPH whom DPH has shared your health information with for purposes other than to provide your health care, pay for your health care or conduct other activities necessary for its operations. To ask for this list, you must send your request in writing to the medical records office at the site where your care was given (see the end of this Notice for a list of addresses). You can ask DPH to provide you with information about who

shared information up to six years before you submitted your request. The first list you ask for within a 12-month period will be free. DPH may ask you to pay for additional lists. The costs will be explained to you, and you may choose to cancel or change your request at any time before you are charged anything.

- **Right to Request Restrictions**. You have the right to ask DPH not to share your health information for treatment, payment, or operations. DPH and/or its doctors do not have to agree to your request particularly if it would harm your care. To ask for restrictions, you must send your request in writing to the medical record office at the site where your care was given (see the end of this Notice for a list of addresses). If you pay for a service or health care item out-of-pocket in full, you can ask DPH to not share that information for the purpose of payment or our operations with your health insurer. In this situation, our request will be approved unless a law requires DPH to share that information.
- **Right to Request Confidential Communications.** You have the right to specify where and how DPH employees may contact you. For example, you can ask DPH staff to contact you only at work or by mail. Let us know in writing, by sending your request to the site where your care is given (see the end of this Notice for a list of addresses). You do not need to give a reason for your request. All reasonable requests will be approved. Your request must tell how and where you wish to be contacted.
- **Right to a Paper Copy of This Notice**. You have the right to receive a paper copy of this Notice. You may ask for a copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you still have the right to a paper copy of this Notice. To obtain a paper copy of this Notice, ask any DPH health care provider. You may get a copy of this notice at DPH web site, http://www.sfdph.org/
- **Choose Someone to Act for You**. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

HOW DPH MAY USE AND SHARE HEALTH INFORMATION ABOUT YOU.

The following categories describe different ways we use and share health information. DPH cannot describe every way it uses health information in this Notice. However, most of the ways fit into one of the descriptions provided below. In all cases, DPH health workers, nurses and doctors will use the minimum amount of information necessary to give you care. DPH regularly reviews the uses and sharing that DPH staff, its contract providers and UCSF staff make from DPH records to be sure they are appropriate.

- **For Treatment.** We use health information about you and share it with other health care professionals who are taking care of you. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes to arrange for special meals. Different

  departments of DPH may share information about you to provide things you need, such as medications, lab tests or x-rays. If you need care with another doctor or facility outside DPH, health information about you may be shared with them to plan your continuing care.

- **For Payment.** Health information about you may be used and shared so that the treatment and services you get at a DPH care site may be billed to and payment collected from you, an insurance company or a third party claim recovery service. Information may be shared with an eligibility service so that it may look for programs to help patients pay for their care. It may also be necessary to tell your health plan about a treatment you need in order to get prior approval or to determine whether your plan will cover the treatment.
- **For Operating DPH Health Care Facilities.** Health information about you may be used and shared for DPH operations. DPH may need to use and share this information to run its programs and make sure that all DPH patients receive quality care. For example, DPH may use your health information to review treatment and services and to check on the care you receive from DPH health workers. Collections of information about many DPH patients may be compared with information from other non-DPH health care settings to see whether care and service at DPH can be improved. Information may be shared with DPH doctors, nurses, technicians, and other DPH staff for review and learning purposes.
- **Appointment Reminders.** DPH may use information it has about you to remind you about an upcoming appointment. Remember, however, that you always have the right to ask DPH to contact you in other ways if you don't want to receive the appointment reminder in the mail, text, or email.
- **Directory.** Certain limited information about you may be included in patient directories at DPH hospitals where you are being treated. This information may include your name, location in the hospital/clinic, your general condition (e.g., fair, stable, etc.) and your religious affiliation. The directory information, except for your religious affiliation, may also be shared with people who ask for you by name. Your religious affiliation may be given to a priest, rabbi or minister, even if they don't ask for you by name. This is so your family, friends and clergy can visit you and know how you are doing if you stay in a DPH hospital. If you do not want DPH to share your name and other information, you must inform the office of admissions in the hospital where you are receiving care.
- **Individuals Involved in Your Care or Payment for Your Care.** Health information about you may be shared with a friend or family member who is involved in and/or responsible for your medical care and who needs to know the information to help you. Information may also be given to someone who will help pay for your care. In addition, health information about you may be shared with an organization helping in a disaster relief effort so that your family can be told about your condition, status and location.
- **Research.** Health information about you may be used and disclosed for research purposes in two ways. First, it may be used by researchers in studies you have been asked to participate in, where you agree to actually take a drug or have a treatment that is being studied for its effectiveness. In these kinds of studies, you will always be asked to consent to your involvement in the study.

  Second, health information about you may be used and disclosed without identifying you. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition, with no names or other personal information being included. All research projects performed in DPH, however, are subject to a special approval process. This process evaluates a proposed research project and its use of health information, to ensure that the research poses no more than minimal risk to your privacy. Before health and/or personally identifiable information is used or disclosed for research, the project

will have been approved through this research approval process, and the researcher will have signed an oath of confidentiality.

- **As Required By Law.** Health information about you may be shared when required by federal, state or local law.
- **To Avert a Serious Threat to Health or Safety.** Health information about you may be used and shared with law enforcement officials when necessary to prevent a serious threat to your health and safety or the health and safety of the public. Any disclosure, however, would only be to someone able to help prevent the threat.

SPECIAL SITUATIONS:

Information may be shared without your okay in the following situations if they apply to you:

- **Organ and Tissue Donation.** If you want to donate an organ, health information may be given to organizations that handle organ donation or organ, eye or tissue transplantation or to an organ donation bank.
- **Military and Veterans.** If you are a member of the armed forces, health information about you may be shared as required by military command authorities.
- **Workers' Compensation.** Health information about you may be given for workers' compensation claims processing or similar programs. These programs provide benefits for work-related injuries or illnesses.
- **Public Health Risks.** State and Federal law may require that DPH share your health information for public health activities. These activities generally include the following:
    - To prevent or control disease, injury or disability;
    - To report births and deaths;
    - To report reactions to medications or problems with health care products;
    - To notify people about recalls of products they may be using;
    - To notify a person who may be catching or spreading a disease or condition; and
    - To notify an authority if it is believed a patient has been the victim of abuse, neglect or domestic violence as required by law.
- **Health Oversight Activities.** The law may require DPH to share your health information with an agency that reviews DPH health care activities. Review activities include, for example, audits, investigations, inspections, and licensing. These activities are necessary for the government to monitor the health care system, programs paid for by taxpayers and DPH adherence to civil rights laws.
- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, health information about you may be shared in response to a court or administrative order. Health information about you may also be shared in response to a subpoena, discovery request or other process by others involved in a dispute, but only if their attorneys have tried to tell you about the order so that you have an opportunity to object within the timelines established by law.
- **Law Enforcement.** Health information may be shared with a law enforcement official:
    - In response to a court order, subpoena, warrant, summons or similar process;
    - About a death believed to have been the result of criminal conduct;
    - About criminal conduct at a DPH facility; and

- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of a person who committed a crime.

- **Coroners and Medical Examiners.** The law may require DPH to share your health information with a coroner or medical examiner. This may be necessary, for example, to identify a dead person or determine the cause of death.
- **Court-appointed Conservators and Public Guardians.** Without asking you, DPH may share your health information with individuals appointed by a court of law to look after your physical and/or mental health and financial well-being.
- **National Security and Intelligence Activities.** Without asking you, DPH may share your health information with authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.
- **Protective Services for the President and Others.** DPH may share health information about you with authorized federal officials so they may provide protection to the President or foreign heads of state. DPH may share health information with other authorized persons to conduct special investigations.
- **Inmates.** If you are an inmate of a jail or prison or under the custody of a law enforcement official, DPH may share your health information with the jail/prison staff or its correctional officers. DPH would have to share this information (1) for the jail/prison to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the jail/prison staff.
- **Court-Appointed Treatment.** In cases in which a person has been ordered to obtain treatment from DPH by a criminal court proceeding, the individual will be asked to okay the sharing of information with that court. If the person later retracts the okay, the court must be informed of the individual's subsequent refusal.
- **Comply with State Laws.** There are certain state laws that protect some types of health information such as certain behavioral health services and HIV test results. We will obey these laws when they are stricter than this notice.

IF YOU BELIEVE YOUR PRIVACY RIGHTS HAVE NOT BEEN MAINTAINED while receiving DPH services, you may file a complaint with DPH or with the U.S. Secretary of the Department of Health and Human Services. All complaints must be sent in writing. Please see the end of this Notice for a list of addresses and phone numbers for the DPH Privacy Office and the Secretary. You will not be penalized in any way for filing a complaint.

CHANGES TO THIS NOTICE

DPH reserves the right to change this Notice and to make the revised or changed Notice effective for health information already recorded about you as well as any information recorded in the future. A copy of the current Notice will be posted in DPH care facilities. The notice will have the effective date on the top of every page.

AUTHORIZATION FORMS TO REQUEST MEDICAL RECORDS (Health Information Services) CAN BE OBTAINED AT THE FOLLOWING DPH LOCATIONS:

San Francisco General Hospital and Trauma Center
Health Information Services,
Main Bldg. 5 Rm. 2B1
1001 Potrero Ave.,
San Francisco, CA 94110 (628) 206-4432

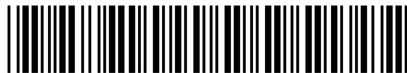
OR

LOCATION WHERE YOU ARE RECEIVING SERVICES

All other privacy concerns and complaints:
DPH Office of Compliance & Privacy Affairs
101 Grove Street, Rm 400,
San Francisco , CA 94102 (855) 729-6040 (toll-free)

Where to file a privacy complaint with the federal government

See how to file a health information privacy or security complaint: https://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html?language=es	**For a faster response, use the online portal.** Link to file online a heath information privacy or security complaint: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf
Address to mail a complaint: Centralized Case Management Operations U.S. Department of Health and Human Services 200 Independence Avenue, S.W. Room 509F HHH Bldg. Washington, D.C. 20201	



T-HI0001

NAME
DOB
MRN
PCP
Patient ID

San Francisco Department of Public Health

SFDPH Summary Notice of HIPAA Privacy Practices and Acknowledgement of Receipt

Full Notice: You have been provided the Full Notice of HIPAA Privacy Practices. Please read it carefully. You can also find it at: https://www.sfdph.org.

Who will follow the rules in this notice: All DPH and contract provider employees, DPH affiliates including staff assigned to DPH by the University of California at San Francisco, and anyone allowed to read, use or give out patients' personal health information must follow these rules.

You have the right to: (Please see possible restrictions in the "Full Notice of Privacy Practices".)

- Request and receive a paper copy of the Full Notice of Privacy Practices.
- Ask to see, read and/or obtain a copy of your health record (charges may be necessary).
- Ask to change information that you believe is wrong in your health record.
- Ask that your health information not be shared with certain individuals.
- Ask that your health information not be used for certain purposes; for example, research.
- Ask that copies of your health record be sent to someone (charges may be necessary).
- Be informed about who has read your record (for reasons other than treatment, payment and operations).
- Specify where and how DPH employees may contact you.

DPH may use and disclose your health information to improve your treatment.

- To improve the quality of care you receive, health information may be shared between treatment providers, both within and outside of DPH.
- There are circumstances when health information about you will not be shared unless you first give your permission for it to be shared.

If you believe your privacy rights have NOT been maintained while receiving DPH services, you may file a complaint. If you have concerns about how your health information might be (or has been) shared, please speak with your provider or contact either of the following: (1) DPH Office of Compliance and Privacy Affairs, 101 Grove St., Room 400, San Francisco, CA 94102 or call toll-free 1-855-729-6040. (2) Write Centralized Case Management Operations, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F HHH Bldg. Washington, D.C. 20201. See "Where to file a privacy complaint with the federal government" in full notice. You will not be penalized in any way for filing a complaint.

I acknowledge receipt of the SF Department of Public Health "Full Notice of HIPAA Privacy Practices."

SIGNATURE OF PATIENT/RESIDENT/CLIENT OR THEIR REPRESENTATIVE		DATE
PRINT NAME	IF REPRESENTATIVE, SPECIFY RELATIONSHIP	INTERPRETER IF APPLICABLE

STAFF/WITNESS: If written acknowledgement is NOT obtained, please complete the following:

☐ Unable to sign ☐ Declined to sign ☐ Other, Describe:	
SIGNATURE OF STAFF WITNESS	DATE
PRINT NAME	DEPARTMENT/ORG

Original-Medical Record_Consent for HIPAA

SF Department of Public Health
SF Health Network

PERMISSION TO SHARE YOUR SUBSTANCE USE DISORDER (SUD) TREATMENT NOTES

NAME
DOB
MRN
Patient Label/Information

The San Francisco Department of Public Health (DPH) is committed to providing you with the best possible care. Our clinical team members need to understand all your medical history and care within DPH so they can offer you the safest and best care. To do this, we are asking your permission to share all information related to substance use (drug and alcohol use).

Completion of this document means you are giving permission to the use and/or disclosure of your substance use disorder information, as detailed below, according to California and federal law. Please provide all information marked with an asterisk (*) otherwise this authorization is not valid.

***Name**____

***Date of Birth**__________ **MRN/BIS#** _________________________

Who can share and Receive my Personal Substance Use Information
I authorize (select one of the following*)
_Initials_________ All Users of SFDPH Electronic Health Records (EHR)
This includes but is not limited to providers and authorized staff at DPH, UCSF and other DPH community partners

OR

__Initials_____ In addition to the above, I ALSO consent to having my substance use notes shared via a health information exchange, such as Epic CareEverywhere. This exchange would allow other health care organizations or providers where I get care to have access to my substance use notes.

What will They be Sharing
I understand that some information must be documented and shared in the DPH Electronic Health Record (EHR), such as medical diagnoses, medications, allergies, immunizations, and test results. **This information is shared across clinical care teams using the DPH Electronic Health Record (EHR).** This clinical information cannot be blocked from being shared.

I understand that my substance use (drug and alcohol) information can be used for the purpose of substance use disorder treatment, payment and operations; care coordination and quality improvement.

How long am I giving my Permission to Share this Information

I understand that I may revoke this authorization at any time. Unless I revoke my consent earlier, this consent will expire automatically upon ten (10) years after the date of my death.

Redisclosure – Telling my Information to Someone Else

If health information is disclosed to someone who is not legally required to keep it confidential, it may be redisclosed (told to someone else) and may no longer be protected. This is a California law.

MY RIGHTS

- I may decide not to sign this authorization.
- I may revoke (change my mind about) allowing sharing of my SUD information at any time. Changing my mind must be in writing, signed by me or on my behalf by someone with the legal authority to do so and delivered to my provider site.
- My revocation (changing my mind) will be effective when my provider site receives it, but I understand my information that has already been shared cannot be taken back.
- I have a right to obtain a copy of this authorization.
- **If I refuse to consent to a disclosure, I will still receive services.**

*Signature: ________________________________ *Date: ______________

Parent/Guardian/Conservator Signature: _________________________________

Interpreter ID: _________Witness:________________________________

NOTE TO RECIPIENT OF SUD INFORMATION:
Pursuant to Section 2.32 of 42 CFR, the following notice is also provided: Federal law/42 CFR part 2 prohibits unauthorized disclosure of these records**.**

SFDPH Use Only: Patient has declined to sign this Permission Form. I have discussed this form and have answered the patient's questions. Patient has been informed that certain clinical information will be shared by all providers. Patient appears to understand our discussion and wishes to receive care.

Provider Signature_________________________ Date: ____________