San Francisco Department of Public Health
Community Behavioral Health Services
Assisted Outpatient Treatment (AOT) Program

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION FORM

Failure to provide ALL information marked * may invalidate this authorization

Client Name*	Date of Birth*
Aliases	SS Number

I have received the Notice of Privacy Practices and been informed that the AOT Care Team may share my protected health information with other members of my treatment team.

In addition, I authorize the AOT Care Team (*email and phone number*) to disclose/exchange information to the following programs or individuals for the purposes of coordinate care, plan treatment, assess for appropriate level of care, and/or assess appropriateness for Assisted Outpatient Treatment (AOT).

Name*	Relationship to Client	Phone Number / Email

Initial for sensitive classes of information*:

___Mental Health History and Treatment ___Alcohol/Drug Use History and Treatment ___HIV/AIDS Test Results/History

___Sexual Transmitted Diseases History ___Developmental Disabilities

Expiration*:
Unless I revoke this authorization, my authorization will expire upon 365 days from the date of execution or termination from program, whichever occurs first, unless a different end date or event is specified: ______________________________ (date/event)
or immediately upon fulfillment.

My Rights:

1. I understand that authorizing the disclosure of this health information is voluntary.
2. I understand that I may not be denied treatment, payment, enrollment in a health plan or eligibility for benefits if I refuse to sign.
3. I understand that I have a right to receive a copy of this authorization.
4. I understand that I may cancel my authorization at any time by writing a note of cancelling and giving it to a member of the AOT Care Team. I also understand that when I give or cancel my authorization, it is effective from that date forward and not retroactively.
5. I understand that information disclosed as a result of this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA).

____ ____________________
Client/Patient Signature* Date*

____ ____________________
AOT Care Team Member Interpreter Used (if any)