Authorization to Release Confidential Information

I, _____ *(Name)*, _____ *(Date of Birth)*, hereby authorize that Lyon-Martin Community Health Services exchange my confidential health information with:

Organization/Individual: The Transgender District & The City & County of San Francisco

Address: 1067 Market St SF, CA 94103 & 1 Van Ness Ave SF, CA 94103 Email (if applicable): N/A

Phone Number: N/A Fax (if applicable): N/A

I would like to authorize Lyon-Martin Community Health Services to:

- ☒ Communicate with the other organization/individual
- ☐ Send Documents to the other organization/individual
- ☐ Receive Documents from the other organization/individual

This authorization includes the release of the following information:

- ☐ All medical records
- ☐ All mental health records
- ☐ TB clearance results
- ☐ Substance use disorder records
- ☐ Current medication list
- ☐ Letter of Support/Clearance for Surgery
- ☐ Lab Results
- ☐ Immunization Record
- ☐ Diagnoses
- ☐ Sexual health records and testing, including HIV
- ☐ Reproductive health records, including abortion
- ☐ Billing Records
- ☐ Not Listed (please specify): Documents and communication relating to the GIFT Program

Date(s) (if applicable): 11/2022-6/2024 Purpose of release: GIFT Program operations

I understand that:

- My health records are protected under federal HIPAA regulations *(42 C.F.R Part 2 and the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. 160 & 164)* and cannot be disclosed without my written authorization unless otherwise provided by the regulations.
- I may revoke this authorization at any time, and revocation must be made in writing.
- To revoke the authorization, I will send the clinic a letter, fax, or patient portal message stating that I want to revoke my authorization to release information to the organization/individual named above. The revocation will take effect once the clinic has received the revocation, will only apply to future disclosures after the date of receipt, and cannot cancel actions or disclosures already made while the authorization was previously in effect.
- I am entitled to a copy of this authorization, and I am signing this authorization voluntarily.
- If I choose not to sign this authorization, access to care will not be affected.

Unless I revoke my authorization, this release will remain in effect for 2 years from the signing of this form or until this expiration date:_____

Printed Name	Signature	Today's Date
Click or tap here to enter text.		Click or tap to enter a date.