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 authorize ____ to disclose the following information: **Documents and information learned as a result of Glide assessment of my treatment history and current needs.**

Initial for protected classes* of information:

_____Mental Health History _____HIV/AIDS/HCV Test Results/History _____Alcohol/Drug Use History

_____Sexually-Transmitted Diseases History

Purpose of disclosure: **To facilitate linkage with medical care.**

Frequency of disclosure: **At the initial screening and assessment, and on a weekly and at times daily basis during the course of this service until Expiration Criteria are met (see below).**

Disclosure will be made by:	GLIDE FOUNDATION, 330 Ellis Street 5th Floor San Francisco, California 94102 (415) 674-5180, FAX (415) 771-8420
Disclosure will be provided to:	____ (Name, title, & address or phone number of person/organization authorized to receive this information)
Expiration Criteria:	Unless revoked, this authorization will expire on (date):_________________________ or on the following event/condition_________________________________. If protected*, authorization will expire immediately following fulfillment of purpose.

My rights:

- ❑ I understand that authorizing this disclosure of my health information is voluntary. I may refuse to sign this authorization. I may not be denied treatment, payment, enrollment in a health plan or eligibility for benefits if I refuse to sign.
- ❑ I understand that I may cancel this authorization at any time by notifying a staff member of either agency above. I also understand that when I give or cancel my consent, it is effective from that date forward, and not retroactively.
- ❑ I understand that Healthcare organizations are bound by rules that govern the use and disclosure of protected health information. The recipients of this health information will not further use or disclose this information to any non-GLIDE entity, unless another authorization is obtained from me.
- ❑ I understand that I have a right to receive a copy of this authorization.

____ ___________

Client/Patient Signature **Date**

____ ___________

GLIDE Staff Signature **Date**

____ ___________

Parent/Guardian/Conservator Signature (if Client/Patient is unable to sign) **Date**