AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

(This form is available electronically upon request)

HEALTH CARE PROFESSIONAL - The person listed below has applied for an accommodation for his/her disability and is required to obtain a certification to verify the disability and the need for the accommodation listed below. Please complete pages 3-4 of this document.

THE FIRST TWO PAGES ARE TO BE COMPLETED BY THE RESIDENT OR APPLICANT REQUESTING THE ACCOMMODATION, WHEN YOU HAVE COMPLETED THIS PAGE, PLEASE RETURN IT TO YOUR SPECIALIST OR MANAGER.

This Request is made on behalf of: ☐ Head-Of-Household ☐ Another________________________________

________________________________ ____
Tcode Name

____ ____
Address city/State/Zip

Phone(s)_______________________________ Alt Phone__________________________________

Type of Accommodation(s) Requested: (PLEASE PRINT LEGIBLY) ___________________________________

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Physician/Health Care Professional's Name: ____

Name of Employer or Practice: ____

Address:____

Phone: ____________________________ Fax: _________________________ Date: __________

I hereby voluntarily authorize the Physician/Health Care Professional named above to disclose information from my record to the Housing Authority of Sacramento on the attached verification form for the purpose of verifying my disability status and need for an accommodation. The Housing Authority may use the information solely for such purpose.

AUTHORIZATION EXPIRATION AND REVOCATION

I understand that I may revoke this authorization in writing at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization. If this authorization has not been revoked, it will terminate one year from the date of my signature, unless I have specified a different expiration date or expiration event.

SPECIFYING A SHORTER TERM AUTHORIZATION

This authorization should expire on: ___________ or upon the following conditions,

TERMS OF AUTHORIZATION

I understand that the health care provider will not condition treatment or eligibility for care on my providing this authorization.

I understand that information disclosed by this authorization may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a].

I understand that I have the right to receive a copy of this authorization.

Print Name________________________________

Signature___________________________________ Date ________________________

Housing Authority Use Only:

Faxed to Medical Professional on: ________ (Date) Faxed By: _____________________

Tenant Code: ____________________

Housing Specialist: ___________________

HS Code: ______________________

☐ HCV Resident ☐ HCV applicant

☐ PH Resident ☐ PH applicant

rev 03/10/2017

Equal Housing
Opportunity