

AUTHORIZATION FOR USE OR RELEASE OF INFORMATION

To: _____ (Insert name of Physician or Provider)

I hereby authorize the use or disclosure of my individually identifiable health information (“Protected Health Information”) as described below in this form (this “Authorization”) to ATC Paratransit for purposes of determining my eligibility to receive transportation services.

Patient’s Name: _____ Today’s Date _____

Please send requested information to:

San Francisco Paratransit, 68 12th Street, San Francisco, CA 94103

Specific description of Protected Health Information to be used or disclosed:

Our applicant’s, your patient’s documented disability(ies) and how it(they affect his/her ability to independently use Muni or BART’s otherwise accessible buses/trains.

Event after which this Authorization expires:

Professional verification of specific information being requested (see above) which allows us to make an ADA Paratransit eligibility determination.

I understand that my Protected Health Information is subject to redisclosure to the authorized recipient of the Protected Health Information pursuant to this Authorization and that the released Protected Health Information may no longer be protected by federal privacy regulations. I also understand that I may revoke this Authorization at any time by notifying you in writing, but if I do, it will not have any effect on any actions you took before you received the revocation of this Authorization.

Signature of individual or individual’s representative _____
Date

(Form MUST be completed before signing)

If applicable, printed name of individual’s representative: _____

Relationship to the individual: _____

Witness _____
Date

(This form is available in accessible formats and/or alternative languages upon request.)