City and County of San Francisco

London Breed, Mayor

Human Services Agency

Department of Human Services
Department of Aging and Adult Services
Office of Early Care and Education

Trent Rhorer, Executive Director

AUTHORIZATION FOR RELEASE OF HSA INFORMATION

I, _____, date of birth _____, hereby authorize the **Human Services Agency (HSA)** to release information about me to the **Department of Homelessness and Supportive Housing (HSH) and HSH-affiliated agencies** for the following purposes:

- To verify my income and benefits more quickly, to help me get evaluated for shelter and/or housing services;
- To help me obtain and/or maintain HSA assistance, benefits and services so I may qualify for housing services.

I understand the information to be released may include the following:

- Public assistance cash aid, benefits and service information
- Medi-Cal Eligibility Data System information (including Medi-Cal status, Social Security, immigration, employment and other state & federal information)
- Documents (including Identification, birth certificate, social security number, citizenship verification, child support information)
- Wages and other income information
- Employability status information (including health and disability information)
- Household expense information
- Case narratives and appointment information
- Other information, as needed, to help get shelter and/or housing services more quickly

MY RIGHTS

I understand I have the right to:

- Refuse to sign this Authorization. If I refuse to sign, it may limit the services I am able to receive.
- Receive a copy of this Authorization.
- Cancel this Authorization. To cancel this Authorization, I understand I must send my signed, written cancellation request to: HSA #S200, P.O. Box 7988, San Francisco, CA 94120-7988. My cancellation will be effective when it is received by HSA, and will not apply to any information that was already shared.
- Inspect my HSA case records by contacting the HSA Custodian of Records at (415) 503-4889.

By signing this Authorization, I acknowledge that this form was read by me (or read to me) prior to signing. This Authorization is valid for one year from the date this Authorization is signed or until my written cancellation is received by HSA.

_____ _____

Client or Authorized Representative Signature | Date

_____ _____

Name of Authorized Representative (AR), if applicable | AR's Relationship to Client

(HSA → HSH: 2019-06)