Date: Jan. 11, 2011

Item No. 3
File No.

SUNSHINE ORDINANCE TASK FORCE

COMPLAINT COMMITTEE

AGENDA PACKET CONTENTS LIST*

☒	**Jason Grant Garza v Haight Ashbury Free Clinics**
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Completed by: **Chris Rustom** **Date:** **Jan. 6, 2010**

***This list reflects the explanatory documents provided**

~ Late Agenda Items (documents received too late for distribution to the Task Force Members)

** The document this form replaces exceeds 25 pages and will therefore not be copied for the packet. The original document is in the file kept by the Administrator, and may be viewed in its entirety by the Task Force, or any member of the public upon request at City Hall, Room 244.

<complaints@sfgov.org>
12/17/2010 04:07 PM

To <sotf@sfgov.org>
cc
bcc
Subject Sunshine Complaint

To:sotf@sfgov.orgEmail:complaints@sfgov.orgDEPARTMENT:Haight Ashbury Free Clinics
CONTACTED:John Eckstrom, Nazneen Abdullah
PUBLIC_RECORDS_VIOLATION:Yes
PUBLIC_MEETING_VIOLATION:No
MEETING_DATE:
SECTIONS_VIOLATED:
DESCRIPTION:All documents inclusive of medical records generated, emails, correspondence, logs, notes of conversation, notes of phone calls concerning the denials (my seeking MEDICAL CARE AT HAIGHT ASHBURY FREE CLINIC on two visits - October 28, 2010 and the followup November 1, 2010) the medical denial, lack of proper referral (given the correct nature of the facts listed in my medical file and the conversation held with the professional) and no correct response to questions asked . Please note that upon PROPER REQUEST I was asked to leave and provided NO MEDICAL CARE, NOR PROPER (see file inclusive of my disability ramifications - ADA) REFERRAL for a duty that MUST BE FILLED UNDER LAW that I was denied by the HAIGHT ASHBURY FREE MEDICAL CLINIC. This request includes all paperwork sent, received, emailed or any other form of transmittal to all involved. This request includes all paperwork sent, received, emailed or any other form of transmittal from all involved. This request also includes all internal documentation generated by this matter also. (From inception to present date) ... for example any documentation, notes, logs, tapes, emails, etc from any individual to any other individual regarding any matter concerning this matter, its handling, deposition, etc.
HEARING:Yes
PRE-HEARING:No
DATE:12/17/2010
NAME:Jason Grant Garza
ADDRESS:1369 B> Hayes St.
CITY:San Francisco
ZIP:CA 94117
PHONE:922-7781
CONTACT_EMAIL:jaygarza@pacbell.net
ANONYMOUS:
CONFIDENTIALITY_REQUESTED:No

Jason Grant Garza
<jasongrantgarza@yahoo.com>
12/09/2010 09:28 AM

To sotf@sfgov.org, jaygarza@pacbell.net
cc NAbdullah@hafci.org, JEckstrom@hafci.org
bcc
Subject Sunshine Task Force - IDR Complaint

12/9/2010

Chris Rustom
Sunshine Task Force
415-554-7724

Dear Mr. Rustom:

I am forwarding this as a complaint that I wish to file with the Sunshine Task Force regarding an IDR. Please process this IMMEDIATELY and notify me. Also I would DEMAND and NOTIFY that this hearing of the complaint be in FRONT OF THE FULL BOARD.

Sincerely,

Jason Grant Garza
jaygarza@pacbell.net
415-922-7781

--- On **Thu, 12/9/10, Jason Grant Garza** ***<jasongrantgarza@yahoo.com>*** wrote:

From: Jason Grant Garza <jasongrantgarza@yahoo.com>
Subject: Fw: IMMEDIATE DISCLOSURE REQUEST (Followup)
To: NAbdullah@hafci.org, JEckstrom@hafci.org, jaygarza@pacbell.net
Cc: Donald.White@oig.hhs.gov, Kathleen.Sebelius@hhs.gov
Date: Thursday, December 9, 2010, 5:14 PM

12/09/2010

NAbdullah@hafci.org (Director of Health Center Operations)
Haight Ashbury Free Clinic
415-746-1931

JEckstrom@hafci.org (CEO)
Haight Ashbury Free Clinic
415-746-1967 ext5ext4

Dear Ms. Abdullah and Mr. Eckstrom:

Again, I am resending this email documenting the still lack of PROPER RESPONSE ... please add this to my file indicative of faulty procedure, unaccountable process and delay by HAFCI regarding medical care and its FALSE MOTTO ... "Health Care is a Right, Not a Privilege" (on HAFCI letterhead and paperwork.)

To date I have NOT received the requested information, an explanation of this delay regarding a Sunshine Request that was due 24 hours after your receipt of notification, or other matters listed in my previous emails.

This is being noted for the file to be provided to others.

Sincerely,

Jason Grant Garza
1369 B. Hayes Street
San Francisco, CA 94117

jaygarza@pacbell.net
415-922-7781

email cc:

Kathleen Sebelius - Secretary of Health & Human Services
Donald White - Office of Inspector General

--- On **Wed, 12/1/10, Jason Grant Garza** ***<jasongrantgarza@yahoo.com>*** wrote:

From: Jason Grant Garza <jasongrantgarza@yahoo.com>
Subject: IMMEDIATE DISCLOSURE REQUEST
To: NAbdullah@hafci.org, JEckstrom@hafci.org, jaygarza@pacbell.net
Cc: Donald.White@oig.hhs.gov, Kathleen.Sebelius@hhs.gov
Date: Wednesday, December 1, 2010, 5:08 PM

12/01/2010

NAbdullah@hafci.org (Director of Health Center Operations)
Haight Ashbury Free Clinic

415-746-1931

JEckstrom@hafci.org (CEO)
Haight Ashbury Free Clinic
415-746-1967 ext5ext4

"IMMEDIATE DISCLOSURE REQUEST"

To Whom It May Concern:

Please be sure to forward this to the Custodian of Records, department head or who ever is in charge for compliance per the regulations for correct process.

Pursuant to all relevant provisions of the California Government Codes (Ralph M. Brown Act et al.) and the San Francisco Sunshine Ordinance, California Records Act, and the Federal FOIA Act - I would like to request a copy of the following:

All documents inclusive of medical records generated, emails, correspondence, logs, notes of conversation, notes of phone calls concerning the denials (my seeking MEDICAL CARE AT HAIGHT ASHBURY FREE CLINIC on two visits - October 28, 2010 and the followup November 1, 2010) the medical denial, lack of proper referral (given the correct nature of the facts listed in my medical file and the conversation held with the professional) and no correct response to questions asked . Please note that upon PROPER REQUEST I was asked to leave and provided NO MEDICAL CARE, NOR PROPER (see file inclusive of my disability ramifications - ADA) REFERRAL for a duty that MUST BE FILLED UNDER LAW that I was denied by the HAIGHT ASHBURY FREE MEDICAL CLINIC. This request includes all paperwork sent, received, emailed or any other form of transmittal to all involved. This request includes all paperwork sent, received, emailed or any other form of transmittal from all involved. This request also includes all internal documentation generated by this matter also. (From inception to present date) ... for example any documentation, notes, logs, tapes, emails, etc from any individual to any other individual regarding any matter concerning this matter, its handling, deposition, etc.

Sincerely,

Jason Grant Garza
1369 B. Hayes Street
San Francisco, CA 94117

email cc:

Kathleen Sebelius - Secretary of Health & Human Services
Donald White - Office of Inspector General

Jason Grant Garza
<jasongrantgarza@yahoo.com>
12/13/2010 11:22 AM

To sotf@sfgov.org, jaygarza@pacbell.net
cc
bcc
Subject More paperwork for IDR complaint by Jason Grant Garza against HAFCI.

--- On **Mon, 12/13/10, Jason Grant Garza** <*jasongrantgarza@yahoo.com*> wrote:

From: Jason Grant Garza <jasongrantgarza@yahoo.com>
Subject: FW: RE: Continuing to seek HELP. (My response to Nazneen's 11/19 email)
To: NAbdullah@hafci.org, JEckstrom@hafci.org, jaygarza@pacbell.net
Cc: Donald.White@oig.hhs.gov, Kathleen.Sebelius@hhs.gov
Date: Monday, December 13, 2010, 7:21 PM

12/13/2010

Dear Nazneen:
415-746-1931

I have attached the copy of the HAFCI release form that you sent me in the mail. Please note HAmedrec0002.jpeg under section II My Rights (per your form) 2nd paragraph " I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to receive treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524 with the guidance of a provider .... If I have questions about disclosure of my health information, I can contact the HAFCI clinic manager."

Doesn't the below email indicate that I had questions about the disclosure and receiving it? Why didn't your HAFCI clinic manager followup?

I believe that NOW you can see my need for an INTERPRETER given the deception being played with definitional meaning and legal duty. Your below email states that you need this form back (well, it is attached and unsigned) as I am allowed by your own paperwork. Where are my requested (IDR) items? Please realize that I NOW also need a letter of admission, apology, explanation and damages for the HARM by this very deception ... unless making things right is again NOT a CONSIDERATION of HAFCI.

More sinister yet, why was I not offered the copies? Why was I not told and only MISLEAD into believing per your misrepresentation that signing the form was required before release? As you can see this poses many many many many questions as to purpose, motto, false system of delivery (medical care and response) and lastly the INHUMANITY dispensed by your

organization, these deception methods and lastly the oath to GOD to "DO NO HARM!"

Once again, contact me ASAP since I still await CORRECT PROCESS, your ADA coordinator's call, the requested material, etc.

I am however sure that the SUNSHINE TASK FORCE, ETHICS COMMISSION, ADA, etc will be interested and as such I will continue to point out all the HARM, DECEPTION and INHUMANITY.

Sincerely,

Jason Grant Garza
1369 B. Hayes Street
San Francisco, CA 94117

jaygarza@pacbell.net
415-922-7781

P.S. Thank you for making it obvious "WHOSE BEST INTERESTS YOU ARE LOOKING OUT FOR."

P.P.S. Have a nice day and GOD bless !!!

--- On **Mon, 11/22/10, Jason Grant Garza** *<jasongrantgarza@yahoo.com>* wrote:

From: Jason Grant Garza <jasongrantgarza@yahoo.com>
Subject: FW: RE: Continuing to seek HELP. (My response to Nazneen's 11/19 email)
To: NAbdullah@hafci.org, JEckstrom@hafci.org, jaygarza@pacbell.net
Cc: Donald.White@oig.hhs.gov
Date: Monday, November 22, 2010, 4:42 PM

11/22/2010

Dear Nazneen:
415-746-1931

Thank you for your note and I believe that I have announced my preferences and requests seeking medical care, the ADA officer, the CEO and BOARD member information, etc ... quite clear. Unfortunately, I still await correct process from your end.

For legal clarification ... you have requested in this email that I fill out an "official medical

release form" and this brings up once again the need for an official response. As you can clearly see by my attachments ... I have already received a partial copy of my medical records without signing ANYTHING. Is this form (official medical release form) a policy requirement (of HAFCI) or a legal requirement under federal law which was BROKEN by HAFCI by giving me my medical records without signing. Please let me know as you know my Adjustment Disorder requires clarification and this request is being made under ADA. Maybe your ADA officer can explain.

As before .... please forward this email to the CEO and BOARD,.

List of attachments: Prior medical records from Haight Ashbury Free Clinic ... Medrec0001.jpeg - Medrec0005.jpeg.

Clear as MUD,

Jason Grant Garza
415-922-7781
jaygarza@pacbell.net

P.S. Have a NICE DAY and God Bless !

--- On **Mon, 11/22/10, jaygarza@pacbell.net** ***<jaygarza@pacbell.net>*** wrote:

From: jaygarza@pacbell.net <jaygarza@pacbell.net>
Subject: FW: RE: Continuing to seek HELP.
To: jasongrantgarza@yahoo.com
Date: Monday, November 22, 2010, 4:05 PM

Original Message:

From: Nazneen Abdullah NAbdullah@hafci.org
Date: Fri, 19 Nov 2010 11:44:47 -0800
To: jaygarza@pacbell.net
Subject: RE: Continuing to seek HELP.

Hi Mr. Garza,
I sent you the official forms to file a grievance with both HAFCI and ADA. I also sent you an official medical record request form, which I

need before releasing your records to you. Please return the official grievance form for HAFCI and the medical records release form to me as soon as possible. Also, let me know if you would like me to set up an appointment for you at an alternative clinic. I previously provided you with a list of clinics that you may choose from. Please let me know if you have a preference.
Thank You,
Nazneen

-----Original Message-----
From: jaygarza@pacbell.net [mailto:jaygarza@pacbell.net]
Sent: Thursday, November 18, 2010 10:32 AM
To: Nazneen Abdullah; John Eckstrom; jaygarza@pacbell.net
Subject: Continuing to seek HELP.

11/18/2010

Dear Nazneen Abdullah
415-746-1931

Thank you for your response; however, I am still not sure of the representation being made offering help. As my previous email stated (below) ... I still await services from your clinic after being wrongfully
denied, the circumstances and reason of the denial NOT accurately accounted
for, the false illusion of help NOT addressed, and non-responsive answers
to questions still left.

Where are the email addresses that I asked for instead of the excuse that
the CEO is out? This is needed to bring the BOARD, CEO and others to the problem, representation and lastly failure of services and the SPIN being
put on the DENIAL. I want the BOARD and all to see NOT only the file, I want them to hear the GAME I was subjected to, the lack of options and the
unprofessional mistreatment.

Thank you for the phone number to ADA but I am confused ... are you ADMITTING no ADA coordinator or services offered by HAFCI and how is

that
in keeping with the ADA requirements. Please answer this ... as I still
await the answer to the PS section of my email dated 11/17 as I would
NOT
like there to be a pattern of asking appropriate questions and yet
receiving NO ANSWERS. Please let me know about the coordinator (ADA),
the
first available appointment time for your alternative physician and as
far
as linking with another (other than HAFCI)... I am still awaiting PROPER
and CORRECT performance on your end from your clinic. Since my
adjustment
disorder is holding you accountable and I have NOT received proper care
...
your offer to link does NOT assure me of performance since I am still
awaiting your correct performance.

Also please send me a complete copy of my file, the email addresses
priorly
requested (see below email), name and number of your ADA coordinator and
please do NOT forget that this request is being made under ADA for
ACCOMMODATION and ACCESS taking into account my disability. For all of
this
I have my file to PROVE, DOCUMENT and VERIFY the truth of which I have
been
speaking and pointing out all the FALSEHOODS in this rigged and corrupt
illusion of HEALTH CARE , COMPASSION and HUMANITY.

Sincerely,

Jason Grant Garza
415-922-7781
jaygarza@pacbell.net

P.S. God Bless and HAVE A NICE DAY ....

Original Message:

From: Nazneen Abdullah NAbdullah@hafci.org
Date: Wed, 17 Nov 2010 13:15:37 -0800
To: jaygarza@pacbell.net
Subject: RE: Follow-Up (My response)

Hi Mr. Garza, I was unable to secure an "interpreter" for you through ADA. When I called on your behalf, I was asked to have you call directly to explain what your specific needs are so that ADA can assist you accordingly. Appointment schedules for our alternative physician have not yet been set. Again, I would like to reiterate that the CEO is out on extended sick leave and will not respond to your calls or emails during this time period. I can work with you to help link you to an alternative provider in the community. Please let me know if you would like me to do so.
Thanks,
Nazneen Abdullah

-----Original Message-----
From: jaygarza@pacbell.net [mailto:jaygarza@pacbell.net]
Sent: Wednesday, November 17, 2010 11:08 AM
To: Nazneen Abdullah; jaygarza@pacbell.net
Subject: FW: Follow-Up (My response)

11/17/2010

Dear Nazreen Abdullah:
415-746-1940

Thank you for your email noting how difficult it is to contact me. This
was the reason for my email address as was discussed in our previous conversation. Your email I believe is in response to my voice message left
11/16 and as such I am wondering about all the topics that I left on your
message machine.

First, I asked about the status of my case and when the other doctors would be returning for a new appointment with another doctor at the Haight
Ashbury Free Medical Clinic. I also left word that I would be responding to
the inaccurate letter received by myself from you regarding the circumstances and reason for the denial of medical care that I received from Dr. Sears. As you know per our conversation the "whole truth" is NOT
expressed and as such I will make the record clear. Since I did NOT receive

care ... NO MATTER HOW YOU TRY TO SPIN IT ... I never stopped asking for care. It is your Clinic's inability to provide the care and NOT my lack of seeking treatment that is the issue here. While the wording is clever ... the gist and intent specific (to get me to leave) ... is NOT TRUE , not accurate and as such will continue to file the complaint and continue to REPEATEDLY ask for ADA accommodation, access and an interpreter as discussed in our phone conversation which I took notes to.

Also as you are aware this has been over 15 days that I have sought and continued to follow up on my medical care. Please be aware that I still intend to speak to the BOARD regarding my lack of care, the representation, the false motto of compassion, the "Health Care is a Right, Not a Privilege" (as on your paperwork, and lastly the lie that NO ONE WILL BE TURNED AWAY FOR INABILITY TO PAY.

Please send me the email addresses for ALL the BOARD members and your CEO (John Eckstrom) as I wish to keep them fully informed and in the "loop" of these matters.

I will try to call to speak to you later on and will work on the above mentioned response to your letter ... please be sure to forward this to your CEO and BOARD members.

Sincerely,

Jason Grant Garza
415-922-7781
jaygarza@pacbell.net

P.S. I believe that our conversation, my file inclusive of the CONFESSION show what I received from the city and MEDICARE. I am stating this for the record as I have always; however, it is NEVER mentioned in the responses I receive from the your clinic ... could it be to "muddle" the TRUTH or

maybe
give a FALSE APPEARANCE of doing things right? Please explain this apparent
lack detail.

Original Message:

From: Nazneen Abdullah NAbdullah@hafci.org
Date: Tue, 16 Nov 2010 15:21:27 -0800
To: JayGarza@pacbell.net
Subject: Follow-Up

Hi Mr. Garza,

I have attempted to return your call several times, but have had no success in reaching you. Please let me know if I can help link you to an alternative provider in the community. Per your request, the number for ADA is 1-800-514-0301.

Sincerely,

Nazneen Abdullah

Nazneen Abdullah, MPH

Director of Health Center Operations

Haight Ashbury Free Clinics, Inc.

415-746-1931 office

415-672-9760 cell

1735 Mission Street

San Francisco, CA 94103

"Health Care is a Right, Not a Privilege."(r)

CONFIDENTIALITY NOTICE
This e-mail and any files transmitted with it are the property of Haight Ashbury Free Clinics, Inc., are confidential, and intended only for the named recipient(s) above. If it has been sent to you in error, please notify the sender by reply e-mail and call 415-746-1967 or e-mail HIPAA@hafci.org <mailto:HIPAA@hafci.org> and delete this message immediately from your computer. Any other use, retention, dissemination, forwarding, printing, or copying of this e-mail is strictly forbidden by the Federal HIPAA Laws.
Thank you for your consideration.

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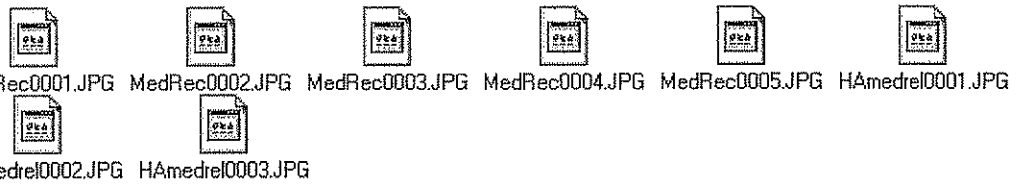
mail2web LIVE - Free email based on Microsoft(r) Exchange technology - http://link.mail2web.com/LIVE



HAFCI Combined Intake Form

Please complete both sides of this form as accurately and completely as possible.

Office Use Only:
MRN _____ %FPL _____ B# _____

Last Name: Garcia First Name Erica Middle Initial J

Social Security Number: 467 - 31 - 1316 Date of Birth 11 / 09 / 60

Address: 1369 B. Hayes St. City: SF State: Ca Zip: 94117

Phone/Cell #: 415 922-9451 ☐ OK to leave a message Work #: (___) _____ ☐ OK to leave a message

Gender: ☐ Female ☒ Male ☐ M to F ☐ F to M ☐ Intersex

Marital Status: ☐ Single ☐ Married ☐ Divorced ☒ Widowed ☐ Decline to state ☐ Other _____

Sexual Orientation: ☐ Bisexual ☐ Gay Male ☐ Straight ☐ Lesbian ☐ Decline to State

Why are you here? Q What's that? → Medical HELP!!!

What is your primary language spoken? _____

Are you a veteran? ☐ Yes ☒ No

Are you HIV positive? ☐ Yes ☐ No Don't know

Race/Ethnicity

☐ Asian	☐ Pacific Islander	☐ Black/African American
☐ White/European	☐ Latino/a	☐ American Indian/Alaskan Native
☐ Decline to state	☒ Other (please specify) Filipina	

What is your living situation? (Please check *all* that apply)

☒ At risk of becoming homeless	☐ Trade
☐ Homeless	☐ Couch surfing
☐ Have been homeless sometime during the last 12 months	☐ Living in a car or van
☐ Residential program/halfway house	☒ Unstable living situation
☐ Sleeping in the park or street	☐ Staying in a shelter
☐ Living in a hotel/SRO (single room occupancy)	☐ Rent or own room/apartment/home
☐ Living rent-free (with friends and family)	☐ Other
☐ Living rent-free (someone else is paying)	Dad & Mother - Don't receive help from because I don't use

Do you have Medical Benefits? ☒ No ☐ Yes *(please specify)*: Pic A Parent Kaiser

☐ Medi-cal ☐ Medicare ☐ Healthy San Francisco ☐ SF Health Plan ☐ Private Insurance (including Kaiser)
☐ HAP card (Family PACT benefits card) ☐ Catastrophic Insurance (high deductible)

PLEASE FILL OUT THE REVERSE SIDE

What is your source of income?

☐ Full time employment ☐ Part time employment ☐ SSI ☒ Disability/SSDI
☐ General Assistance/GA ☐ Unemployment benefits ☐ No source of income
☐ Child dependent on parents ☐ Veteran Benefits ☐ Savings ☐ Student Loan

What is your weekly income before taxes?: $_____ per week

Including yourself, how many people are you financially responsible for? Two +2

Are you interested in any other HAFCI services? (Please check *all* that apply)

☐ Primary Care Physician
☒ Dental
☐ Women's Health
☐ Homeless Services
☐ Case Management
☐ Substance Abuse Treatment: ☐ Men ☐ Women
☐ Confidential HIV Testing
☐ HIV Case Management
☐ STD Screening
☐ Anger Management
☐ Women's Detox
☒ Other Don't know what it

I give my consent to be contacted about other HAFCI services GAC (initial here) [illegible]

Were you referred to us by another organization/agency? If so, which one? No

Are you receiving any services at any other HAFCI Program? Yes____ No X

If yes, where?_____

Who should we contact in the event of an emergency?

Name: [illegible] Phone: (____) _____

Relationship to you: _____

All answers are strictly confidential

PLEASE READ AND SIGN BELOW

To the best of my knowledge, the information provided here is true and accurate. I give my permission to be treated by the Haight Ashbury Free Clinic and I hereby authorize the dispensing of any medication to me in non-locking containers.

Patient Signature: [illegible] Date: 10/23/10

A parent or guardian must sign if the patient is under 18 years of age but not if the patient is an emancipated minor.

Office Use Only:

Staff Signature: _____ Date: _____

☐ 1st request date for proof of income: _____ ☐ 2nd request date for proof of income: _____
☐ Date proof of income obtained: _____ ☐ State source: _____

Haight Ashbury Free Clinics

Office Use Only: MRN _____

Name (last) Garcia (first) Jesse Date 10/28

Health History Form

Your answers on this form will help your health care provider understand your medical concerns and conditions better. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please provide your best guess. Thank you!

Age 22 Gender: ☐ Female ☑ Male ☐ M to F ☐ F to M ☐ Intersex

Main Health Concern: Kidney Health Check

Other concerns: Low Back Pain

REVIEW OF SYMPTOMS: Please check any current symptoms you have.

Constitutional
- ✓ Recent fevers/sweats
- ✓ Unexplained weight loss/gain
- ✓ Unexplained fatigue/weakness

Eyes
- ✓ Change in vision

Ears/Nose/Throat/Mouth
- ___ Difficulty hearing/ringing in ears
- ___ Hay fever/allergies/congestion
- ___ Trouble swallowing

Cardiovascular
- ✓ Chest pains/discomfort
- ✓ Palpitations
- ✓ Shortness of breath with exertion

Breast
- ___ Breast lump
- ___ Nipple discharge

Respiratory
- ✓ Cough/wheeze
- ___ Coughing up blood

Gastrointestinal
- ___ Heartburn/reflux
- ✓ Blood or change in bowel movement
- ✓ Nausea/vomiting/diarrhea
- ✓ Pain in abdomen

Genitourinary
- ___ Painful/bloody urination
- ___ Leaking urine
- ___ Nighttime urination
- ___ Discharge: penis or vagina
- ___ Unusual vaginal bleeding
- ___ Concern with sexual functions

Musculoskeletal
- ✓ Muscle/joint pain
- ✓ Recent back pain

Skin
- ✓ Rash
- ___ New or change in mole

Neurological
- ✓ Headaches
- ✓ Memory loss
- ___ Fainting

Psychiatric
- ✓ Anxiety/stress
- ___ Sleep problem

Blood/Lymphatic
- ___ Unexplained lumps
- ___ Easy bruising/bleeding

Endo
- ✓ Cold/heat intolerance
- ___ Increase thirst/appetite

**In the past month, have you had little interest or pleasure in doing things, or felt down, depressed or hopeless? ☐ Yes ☐ No

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs, etc.

Medication	Dose (e.g., mg/pill)	How many times per day
Medical Marijuana	As Needed	

Allergies or reactions to medications: None to Date

Date of your most recent **IMMUNIZATIONS:** No Recent Date

Hepatitis A _____ Hepatitis B _____ Influenza (flu shot) _____ MMR _____ Meningitis _____ Tetanus (Td) _____

Pneumovax (pneumonia) _____ Varicella (chicken pox) shot or *illness* _____ Tdap (tetanus & pertussis) _____

HIV INFORMATION: Never Tested

Had a previous HIV Test: ☐ Yes ☐ No Results: ☐ Positive ☐ Negative ☐ Not Sure

Date of last HIV test _____ CD4 _____ Viral Load _____

– OVER –

HEALTH MAINTENANCE SCREENING TESTS: No medical ins for years!!!

Hepatitis A, B, C	☐ Yes ☐ No	Last Test Date _____	Abnormal? ☐ Yes ☐ No
Tuberculosis (TB)	☐ Yes ☐ No	Last Test Date _____	Abnormal? ☐ Yes ☐ No
Lipid (cholesterol)	☐ Yes ☐ No	Last Test Date _____	Abnormal? ☐ Yes ☐ No
Sigmoidoscopy/Colonoscopy	☐ Yes ☐ No	Last Test Date _____	Abnormal? ☐ Yes ☐ No
Dexascan (osteoporosis)	☐ Yes ☐ No	Last Test Date _____	Abnormal? ☐ Yes ☐ No
Women: *Mammogram*	☐ Yes ☐ No	Last Test Date _____	Abnormal? ☐ Yes ☐ No
Pap Smear	☐ Yes ☐ No	Last Test Date _____	Abnormal? ☐ Yes ☐ No
Men: *PSA* (prostate)	☐ Yes ☐ No	Last Test Date _____	Abnormal? ☐ Yes ☐ No

PERSONAL MEDICAL HISTORY: Please check whether you have had any of the following medical problems.

____ Heart Disease:	____ High Blood Pressure	____ High Cholesterol
Specify type _____	____ Diabetes	____ Thyroid Problem
____ Asthma/Lung Disease	____ HIV/AIDS	____ Kidney Disease
____ Cancer (specify): _____	____ Other (specify):	

Further Abuse/Future Hospice Medical Fraud, etc

SURGICAL HISTORY: Please list all prior operations (with dates):

Wife

FAMILY HISTORY: Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

Alcoholism _____	High cholesterol _____
Cancer, specify type _____	High blood pressure _____
Heart disease _____	Stroke _____
Depression/Suicide _____	Bleeding or clotting disorder _____
Genetic disorders _____	Asthma/COPD _____
Diabetes _____	Other: _____

No Family Unknown Dad Father Died

SOCIAL HISTORY

Tobacco Use

Cigarettes ☐ Never ☐ Quit Date _____

☑ Current Smoker: Packs/day _____ # of yrs _____

Other Tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Are you interested in quitting? ☐ No ☐ Yes Maybe someday Why?

Alcohol/Drug Use

Do you drink alcohol? ☑ No ☐ Yes # drinks/day _____

Do you use any recreational drugs? ☑ No ☐ Yes

Have you ever used needles to inject drugs? ☑ No ☐ Yes

Is your alcohol or drug use a concern for you or others? ☐ No ☐ Yes Used to, but not for years

Sexual Activity

Sexually active? ☐ Yes ☐ No ☐ Not Currently Used to, Not

Current sex partner(s) is/are: ☐ Male ☐ Female ☐ Both

Sexual partners in the last month? _____ 3 Months? _____ 12 Months? _____

Birth control method: _____ ☐ None Needed

Have you ever had any sexually transmitted diseases (STDs)? ☐ No ☐ Yes, List _____

Are you interested in being screened for sexually transmitted diseases? ☐ No ☐ Yes

OTHER HISTORY

Caffeine Intake: ☐ None ☑ Coffee/tea/soda 1 cups/day Occasional

Weight: Are you satisfied with your weight? ☑ No ☐ Yes

Diet: How do you rate your diet? ☐ Good ☐ Fair ☑ Poor Very Erratic

Do you eat or drink four servings of dairy or soy daily or take calcium supplements? ☑ No ☐ Yes

Exercise: Do you exercise regularly? ☑ No ☐ Yes

What kind of exercise? _____

How long (minutes) _____ How often? _____

If you do not exercise, why? _____

Safety: Do you use a bike helmet? ☐ No ☐ Yes ☐ N/A

Do you use seatbelts consistently? ☑ No ☐ Yes

Is violence at home a concern for you? ☐ Yes ☑ No

Have you ever been abused? ☑ Yes ☐ No

G by professionals

WOMEN'S HEALTH HISTORY # Pregnancies _____ # Deliveries _____ # Abortions _____ # Miscarriages _____

Age at *start* of periods: _____ Age at *end* of periods: _____

SOCIOECONOMIC Occupation: SAHL Employer: _____

Years of education/highest degree: _____

– OVER –

2/5/10 RR

Summary Haight A. ..t Free Medical Clinic Notice of H. ..A ..acy Practices

This Notice describes how Haight Ashbury Free Medical Clinic (HAFMC) may use and share medical information about you, and how you can get access to this information. Please review this Notice carefully.

Pledge: Employees of HAFMC, its affiliates and contract providers understand that information about you and your health is personal. They are committed to protecting your health information.

Who will follow the rules in this notice: HAFMC employees, its affiliates and contract providers, must follow these rules.

You have the right to: (please see possible restrictions page 2 in the attached full Notice)

- Ask to see, read and/or obtain a copy of your health record (charges may be necessary).
- Ask to correct information that you believe is wrong in your health record.
- Ask that your health information not be shared with certain individuals.
- Ask that your health information not be used for certain purposes, for example, research.
- Ask HAFMC to send copies of your health record to whomever you wish (charges may be necessary).
- Be informed about who has read your record (for reasons other than treatment, payment and program improvement purposes).
- Specify where and how HAFMC employees may contact you.
- Receive a paper copy of the attached HAFMC Notice of Privacy Practices.

HAFMC may use and disclose your health information for the purposes of treatment, payment and health care operations.

- To improve the quality of care you receive, health information may be shared by providers, both within HAFMC for our own treatment purposes, and to inform the treatment that you receive from another health care provider. This sharing may include health information regarding mental health, substance abuse, HIV/AIDS, sexually transmitted diseases (STD), and developmental disabilities.
- Health information may be shared to obtain payment for services that are provided to you, to assist you to pay for your care, or to obtain prior approval for treatment.
- Health information may be shared for health center operations, such as to run our facilities, make sure that all health center patients receive quality care, improve health care delivery, and for learning purposes.
- There are circumstances when health information about you will not be shared unless you first give your permission for it to be shared; such as when you receive services for mental health, substance abuse, or STD, or for some research purposes.
- See the attached "Notice of Privacy Practices" for more information. If you have concerns about how your health information might be (or has been) shared, please speak with your provider or call the Privacy Officer directly at 415-746-1740

If you believe your privacy rights have NOT been maintained while receiving HAFMC services, you may file a complaint with the HAFMC or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with HAFMC, send the complaint to the Privacy Officer at 1735 Mission St., San Francisco, CA, 94103 or call 415-746-1940. To file a complaint with the Secretary, the address is U.S. Dept. of Health and Human Services, Office of Civil Rights, Attn: Regional Manager, 50 United Nations Plaza, Rm. 322, San Francisco, CA 94102. You will not be penalized in any way for filing a complaint.

I acknowledge receipt of the HAFMC "Notice of Privacy Practices." I understand that my signature does not authorize disclosure, but only acknowledges that I have received a copy of the Notice attached.

Signature: _____ Date: _____

Printed Name: _____ Relation (if other than patient): _____

Patient/client declined to sign receipt (staff signature): _____

Patient/client unable to sign (witness signature): _____

Reason unable: _____ Interpreter: _____

Authorization for Haight Ashbury Free Medical Clinic to use/disclose my health information
1735 Mission Street, San Francisco, CA 94103 415-746-1940

Patient name: _____ Date of birth: ___/___/___

Previous name: _____ SS # ___-___-___

My Authorization: I authorize the use or disclosure of the above named individual's health information as described below.

1. **The following person or organization is authorized to make the disclosure: (check only one box)**

☐The Haight Ashbury Free Medical Clinic Medical Record # _____

OR

☐ Name: _____ Phone/Fax: _____

Address: _____ City: _____ St: _____ Zip: _____

2. **You may use or disclose the following health care information** (check all that apply)
☐ All health information (not including HIV, Psych, Substance Abuse unless checked below)
☐ My health information relating to the following treatment or condition:
_____
☐ My health information for the date (s): _____
☐ Laboratory Results only
☐Other: _____

3. **You may use or disclose the following health care information** (initial all that apply)
___ HIV and related medical conditions including blood test results and clinician notes indicating such condition: By initialing this box, I am providing written authorization to disclose such records to the person(s) authorized below.
___ Psychiatric records including results of psychiatric lab work
___ Records containing reference to substance abuse and/or treatment

4. **You may disclose my information to:**
☐ Haight Ashbury Free Medical Clinic ☐Self ☐Other (write in below)
1735 Mission St. SF, CA 94103
Fax: 415-746-1941

Name or Organization _____

Address: _____ City _____ State _____ Zip _____

☐ Check here if you would like to pick up your records: Phone # _____

Patient Name: _____

Authorization for Haight Ashbury Free Medical Clinic to use/disclose my health information
1735 Mission Street, San Francisco, CA 94103 415-746-1940

5. **Reason for this authorization:**
☐ At my request ☐ Other (specify) _____

II. My Rights

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Clinic Manager. I understand that the revocation will apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. **If I fail to specify an expiration date, event or condition, this authorization will expire in one year.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to receive treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524 with the guidance of a provider. I understand that any disclosure of information carries with it the potential for unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the HAFMC clinic manager.

_____ _____

*Patient or legally authorized individual signature *Date

_____ _____

*Print Name if signed on behalf of patient *Relationship to patient

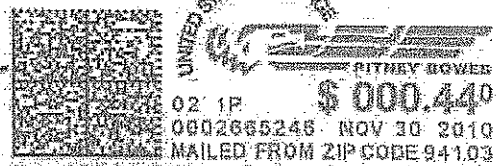
_____

☐ Patient requested and given copy of this request Requesting provider _____

A copy of this form shall be kept in the patients chart

Haight Ashbury Free Clinics, Inc
P.O. Box 29917
San Francisco, CA 94129

Friday
Rec'd 12/10/10



Jason Grant Garza
1369 B. Hayes St.
San Francisco, CA 94117

9411741483

Date: Jan. 11, 2011

Item No. 4
File No. _____

SUNSHINE ORDINANCE TASK FORCE

COMPLAINT COMMITTEE

AGENDA PACKET CONTENTS LIST*

- ☒ **Administrators Report**
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Completed by: Chris Rustom **Date:** Jan 6, 2011

***This list reflects the explanatory documents provided**

~ Late Agenda Items (documents received too late for distribution to the Task Force Members)

** The document this form replaces exceeds 25 pages and will therefore not be copied for the packet. The original document is in the file kept by the Administrator, and may be viewed in its entirety by the Task Force, or any member of the public upon request at City Hall, Room 244.