Internal Use
Received by

Fax completed form to: 707-923-4433 or Mail to: 733 Cedar Street, Garberville, CA 95542

Completion of this document authorizes the disclosure and/or use of health information about you.
Failure to provide all information requested may invalidate this authorization.
Please provide personal identification when presenting your request for medical records.

Patient Name:_____ Date of Birth:_____/_____/_____
Previous Name Used (i.e., maiden name):_____ SSN (optional): _____

Records From:

☐ SoHum Health
☐ Facility Name:_____
Address:_____
City, State, Zip: _____
Phone:_____
Fax: _____

Records to:

☐ Facility Name:_____
☐ Self
Address:_____
City, State, Zip: _____
Phone:_____
Fax:_____
☐ SoHum Health

I am authorizing release of the following information:

a) Health information pertaining to my medical history, mental, or physical condition and treatment received (please indicate specific documents being requested below):

☐ Labs ☐ EKG
☐ Imaging Reports
☐ Imaging Virtual Disc
☐ Emergency Room Visits
☐ Clinic Records
☐ Immunization Records
☐ Other_____

b) The following records will only be released if **initialed**:

_____ Mental Health Information
_____HIV Test Results
_____Alcohol/Drug Treatment Info

c) Please note: The following records will only be released to out of state facilities if **initialed**:

_____Gender Affirming Care
_____Abortion-Related Services
_____Contraceptives

d) Release records only for the following date(s): If Blank, default is two years

_____/_____/_____
To
_____/_____/_____

e) The purpose of requested use or disclosure:

☐ Personal
☐ Continuation of Care
Appt Date____/____/_____
☐ Other_____

This authorization only applies to records specified on this release and expires on_____/_____/_____.
(If left blank, authorization will expire one year from date of signature)

My signature below authorizes the release of my Protected Health Information:

Terms and Conditions on Reverse

_____ _____ _____/_____/_____
Signature If Representative - Relationship Date

Southern Humboldt Community Healthcare District
733 Cedar Street • Garberville, CA 95542 • (707) 923-3921 • sohumhealth.org

Place Sticker Here

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I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits. I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of. I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: Health Information Management, SHCHD, 733 Cedar Street, Garberville, CA 95542. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization. I have a right to receive a copy of this Authorization. Information disclosed pursuant to this Authorization could be redisclosed by the recipient. Such disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law.

CHARGES FOR COPYING RECORDS

SHCHD acknowledges that every patient has the right to request access to their Protected Health Information (PHI). Upon receipt of a signed Authorization for Disclosure, we will make every effort to provide access in a timely and efficient manner according to state and federal law. We would appreciate a minimum of 24 hours to locate your records and process your request. In some cases it may take up to fifteen days to provide copies, depending on the current location of your records and/or volume of requests.

HIPPA and California state laws allow providers to charge a reasonable, cost based fee for providing copies, including the costs of copying (including supplies and labor), and postage (if information is mailed). If records are requested by parties other than the patient, additional clerical time preparing and locating the records may be included in the fee. Please refer to our fee schedule below.

- Records requested for continued care will be provided to another healthcare provider at no cost.
- Patients requesting photocopies for personal use will receive the first 10 pages at no charge; additional pages will cost 25 cents per page. If records are mailed, postage reimbursement may be requested
- Third party requests (i.e. attorneys, insurance companies if not requested to authorize payment) will be required to reimburse clerical time ($4.00 per ¼ hour,) 10 cents a page, and postage if applicable.
- In response to subpoenas, the party issuing the subpoena will be asked to pay "reasonable costs" as defined in Evidence Code Section 1563. Clerical costs will be charged at $6.00 per ¼ hour, 10 cents per page, plus postage.
- Other "reasonable" charges may be requested for services such as inspection of medical records, providing a summary, or reproducing X-rays or EKG tracings, etc.

Resources: California Hospital Association Consent Manual, HIPAA, California Health and Safety Codes