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): _____

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

RECORDS FROM:
☐ Jerold Phelps Community Hospital
☐ Southern Humboldt Community Clinic
☐ Other: _____
Address: _____
City, State, Zip: _____
Phone/Fax: _____

RECORDS TO:
☐ Jerold Phelps Community Hospital
☐ Southern Humboldt Community Clinic
☐ Other: _____
Address: _____
City, State, Zip: _____
Phone/Fax: _____

I am authorizing release of the following information:

a. All health information pertaining to my medical history, mental or physical condition and treatment received (please indicate specific documents being requested below):
❒ Lab ❒ X-Ray ❒ EKG ❒ Emergency Room Visits
❒ Physician's notes and reports ❒ Clinic records

❒ Health records regarding specific dates: From ____/____/____ to ____/____/____

b. I specifically authorize release of the following information (check and initial as appropriate):
_____Mental Health information _____HIV test results _____Alcohol/drug treatment information

The purpose of requested use or disclosure: ❒ Personal ❒ Continuation of care ❒ Other

This authorization only applies to records specified on this release and expires on _____.

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.

_____ _____ _____
Signature If Representative – Relationship Date

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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