Authorization to Exchange Information between Humboldt County Social Services and _____

Completion of this document authorizes the disclosure and use of health, coverage and benefit information about you. Failure to provide all information may invalidate this authorization.

Please print clearly when filling out by hand:

Name of Customer	
Date of Birth (Optional to identify)	
SSN (Optional to identify)	

Use and Disclosure of Health and Coverage Information

I hereby authorize the exchange of information between the Humboldt Department of Health & Human Services (DHHS) Social Services and the following individual, agency or provider: _____

The information pertaining to receiving the following benefits (check all that apply):

☐	CalFresh
☐	Health Care Coverage Programs (Medi-Cal/CMSP/CoveredCA)
☐	CalWORKs
☐	Welfare to Work
☐	General Relief & Transportation Assistance Program (TAP)

These programs are administered by Social Services. Only the following records or types of information connected to the above noted program(s) are to be exchanged (check all that apply):

☐	Eligibility Status such as approval or denial
☐	Benefit Level
☐	Items necessary for benefit approval or retention
☐	Household Income or Resources
☐	Non-financial Information
☐	Welfare to Work Participation
☐	Welfare to Work Supportive Services
☐	Other:

Purpose:

☐ The purpose of the information exchange is to enable the above named to help in obtaining or maintaining benefits for the customer.

☐ The customer has requested this information be shared for personal/unspecified reasons.

My Rights

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 any of the information for which I am authorizing disclosure.

I may revoke this authorization at any time, but I must do so in writing for health care coverage programs and submit it to the following address:

DHHS-Social Services 929 Koster St., Eureka, CA 95501

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 redisclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

Expiration

This authorization will expire on: or automatically one year after signing.

Signature

Date: _____Time: _____AM / PM

Signature: (customer / legal representative) _____

If signed by other than customer, indicate relationship: _____

Print name: _____ (customer / legal representative)

County use: Case #_____ Worker_____

Representative signature accepted: