



RELEASE OF INFORMATION

Form Version 04.14.2025



A release of information between First 5 Humboldt and your direct provider organization is required to receive Welcome Baby: Pathways to Resilience services. Failure to provide all information requested may invalidate this authorization.

Participant Name (Last, First): _____

Date of Birth (MM/DD/YYYY): _____ Phone: _____

Mailing Address: _____

I, _____, hereby authorize First 5 Humboldt to:

☐ receive my information from

☐ provide my information to

Select who you would like First 5 Humboldt to exchange information with from the following options. To receive Welcome Baby: Pathways to Resilience services, at minimum, you must allow First 5 Humboldt to receive information from the organization which your Community Health Worker/Nurse is employed through.

☐ the following organizations who are partnered in the Welcome Baby: Pathways to Resilience program and the necessary program staff involved in my care:

☐ County Public Health Nursing

☐ Redwoods Rural Health Center, Inc.

☐ K'ima:w Medical Center

☐ United Indian Health Services, Inc.

☐ Open Door Community Health Centers

☐ ALL Welcome Baby program partners

☐ the following additional organization, care provider, or individual:

Name: _____

Relationship to you: _____

Phone: _____

☐ Check if they're
located out of CA

The information I authorize for release includes all information necessary for care coordination, program evaluation, and provision of services that are a part of or are directly related to the Welcome Baby: Pathways to Resilience program.

Any limitations I impose on this information with respect to this authorization are listed here: _____.

The recipient may use the information authorized on this form for the purpose of:

Welcome Baby: Pathways to Resilience services including care coordination, benefits, and program evaluations.

I choose to extend this authorization until:

☐ This authorization will expire on (MM/DD/YYYY): _____.

☐ the end of my programmatic care, not to exceed eighteen (18) months from the date of my signature.

By signing below, I understand that:

- I authorize the parties designated above to communicate with and disclose to one another the information I designated above. I recognize the parties designated on this form. I have been offered the current contact information of named Welcome Baby: Pathways to Resilience partners. If the entities I've designated are outside of California, I understand that the ability to share information about my reproductive health may be limited.
- This authorization is voluntary. I may refuse to sign this authorization. Such refusal will not affect my ability to obtain health care treatment except to the extent that the information being requested may assist Welcome Baby: Pathways to Resilience staff in determining, providing, and coordinating appropriate care. My refusal will affect my ability to obtain services under the Welcome Baby: Pathways to Resilience program, but efforts will be made to offer available services under other programs. I will be informed if limitations imposed on this authorization affect my ability to obtain services under the Welcome Baby: Pathways to Resilience program.
- I have a right to receive a copy of this authorization. I may inspect or obtain a copy any of the information for which I am authorizing disclosure.
- This authorization is effective immediately. This authorization will remain in effect unless otherwise revoked until the date listed above, or if no date is listed, until one (1) year from the date of my signature. I may revoke this authorization in full or in part at any time. Revocation must be made in writing and submitted to First 5 Humboldt directly. Revocation will not apply to information that has already been released in response to this authorization.
- Entities that receive my information under this authorization may not be required to follow the same privacy rules as the entity that shared the information and could redisclose my information. Laws are in place to protect certain kinds of information. Any information related to substance abuse disorders or HIV/AIDS treatment that is shared cannot be re-disclosed except with another authorization. Reproductive health information will not be shared for the purpose of investigating or imposing liability on any person for seeking, obtaining, providing, or facilitating reproductive health care. Substance use disorder information will not be used for prosecution against me. Any of my information that may contain juvenile records will be protected as required by state and federal regulations.

Signature: _____ Date: _____

If signed by other than participant, indicate relationship: _____

You may be required to verify that you have decision-making authority for the participant.



RELEASE OF INFORMATION ATTACHMENT A

Form Version 04.14.2025



This form is an attachment to the Release of Information form and should be completed in tandem with a standard "Release of Information" form. Failure to provide all information requested may invalidate this authorization.

This attachment allows Welcome Baby: Pathways to Resilience staff to assist you with your care and services in our community.

Substance use treatment records are protected under federal and state regulations and may only be released with the patient's written consent unless other specific qualifying circumstances are met.

Violation of federal law and regulations by a program is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs. Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

I authorize the release of my specific Substance Use Disorder Records (SUD) as identified below, subject to 42 CFR part 2 as specified below:

☐ Appointments/Admission/Discharge Information ☐ Other: _____

I authorize this information to be released to First 5 Humboldt AND the necessary program staff involved in my care in the Welcome Baby: Pathways to Resilience program, who are employed at the following organization(s):

☐ County Public
Health Nursing
☐ K'ima:w Medical
Center

☐ Open Door
Community Health
Centers
☐ Redwoods Rural
Health Center, Inc.

☐ United Indian
Health Services,
Inc.

This information will be released from:

Organization Name: _____

Organization Address: _____

Point of Contact's Name (if applicable): _____

Point of Contact's Phone: _____

By signing below, I understand that:

- My signature authorizes the parties designated above to receive information for the purpose of coordination of treatment. Only information which is necessary to carry out the goals and intentions of the Welcome Baby: Pathways to Resilience program will be disclosed.
- This authorization is voluntary, and I may refuse to sign this authorization. Such refusal will not affect my ability to obtain health care treatment except to the extent that the information being requested may assist Welcome Baby: Pathways to Resilience staff in determining and coordinating appropriate care.
- I have a right to receive a copy of this authorization. I may inspect or obtain a copy any of the information for which I am authorizing disclosure.
- This authorization is effective immediately and will expire at the same time as the standard "Release of Information" form it is attached to unless otherwise revoked. Releases of information may be revoked in part or completely at any time. Revocation must be made in writing and submitted to First 5 Humboldt directly. Revocation will not apply to information that has already been released in response to this authorization.
- I recognize the parties designated on form, and I have been offered the current contact information of named Welcome Baby: Pathways to Resilience partners.
- Substance use disorder information may not be re-disclosed unless another authorization for such disclosure is obtained from me, or unless such disclosure is specifically required or permitted by law.

Print Name: _____

Signature: _____ Date: _____

If signed by other than participant, indicate relationship: _____

You may be required to verify that you have decision-making authority for the participant.



RELEASE OF INFORMATION ATTACHMENT B

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This attachment provides further contact details for the partnered agencies of the Welcome Baby: Pathways to Resilience program. Necessary program staff employed at these locations may be involved in your care. Necessary staff typically includes but are not limited to: Community Health Representatives (also called Community Health Workers or Navigators) and Nurses.

County Public Health Nursing

Public Health Main Office
529 I St
Eureka, CA 95501
707-268-2105

K'ima:w Medical Center

535 Airport Rd
Hoopa, CA 95546
530-625-4261

Open Door Community Health Centers

Redwood Community Health Center
2350 Buhne St Ste A
Eureka, CA 95501
707-443-4593

Redwoods Rural Health Center, Inc.

101 West Coast Rd
Redway, CA 95560
707-923-2783

United Indian Health Services, Inc.

Potawot Health Village
(Tribal Public Health)
1600 Weott Way
Arcata, CA 95521
707-825-5070

Elk Valley Office
2298 Norris Ave
Crescent City, CA 95531
707-464-2919

Weitchpec Health Village
(Libby Haripop Nix Community Center)
23001 State Hwy 96
Weitchpec, CA 95546
530-625-4300

First 5 Humboldt

325 Second St Ste 201
Eureka, CA 95501
707-445-7389
welcomebaby@co.humboldt.ca.us