GREATER NEW HAVEN COORDINATED ACCESS NETWORK
AUTHORIZATION FOR RELEASE OF INFORMATION

This authorization is voluntary. The information you authorize us to disclose may be subject to re-disclosure by the recipient and if the person or organization authorized to receive the information is not a health plan or health care provider, the information may no longer be protected by Federal privacy regulations. We may not condition your receipt of treatment, payment, enrollment, or eligibility for benefits of this authorization.

NAME (First, Last):_____ **DATE OF BIRTH:**_____

I hereby authorize the agencies listed below (visit https://uwgnh.org/can-partners for the most up to date release) to exchange the indicated information for the purpose of ensuring effective coordination of services. Initial each type of information to release:

Medical/ Mental Health	Education/ Employment	Criminal/ Legal	Housing	Substance Treatment	HIV/AIDS	Other (indicate here)	All the above
_____	_____	_____	_____	_____	_____	_____	_____

Agencies covered by the terms and conditions of this authorization are:

- — A Place to Nourish Your Health
- — Amtrak Police
- — APT Foundation
- — Beacon Health Options
- — Beth-El Center
- — BHCare
- — Branford Counseling Center
- — Bridges Healthcare
- — Career Resources/STRIVE
- — Christian Community Action
- — City of New Haven
- — Columbus House
- — Community Action Agency of New Haven
- — Community Dining Room
- — Connecticut Court Support Services Division
- — Connecticut Department of Children and Families
- — Connecticut Department of Corrections
- — Connecticut Department of Housing
- — Connecticut Harm Reduction Alliance
- — Connecticut Health Network
- — Connecticut Mental Health Center
- — Connecticut Dept. of Mental Health and Addiction Services
- — Continuum of Care
- — Cornell Scott Hill Health Center
- — Connecticut Coalition to End Homelessness
- — Department of Social Services
- — Downtown Evening Soup Kitchen
- — Emergency Shelter Management Services
- — Fair Haven Community Health Clinic
- — Fellowship Place
- — Griffin Hospital
- — Integrated Wellness Group
- — Jewish Family Services
- — Junta FOR Progressive Action
- — Leeway New Haven
- — Legal Assistance Association
- — Liberty Community Services
- — Loaves and Fishes
- — Marrakech, Inc
- — New Reach
- — Project MORE
- — RM4 Drop In Center
- — Spooner House/ACT, Inc
- — TEAM, Inc
- — The 180 Center (seasonal)
- — The Connection, Inc.
- — Town of Hamden
- — Trinity on the Green Church
- — United Way of Greater New Haven
- — United Way of Milford
- — Upon this Rock Ministries (seasonal)
- — Varick Memorial AME Zion Church (seasonal)
- — Vertical Church
- — Veterans Service Administration
- — VNA South Central Connecticut
- — Women and Family Life Center
- — Workforce Alliance/American Job Center
- — Yale-New Haven Hospital
- — Youth Continuum
- — Y2Y Network
- — Other: _____

I understand that some or all my information may be protected under Federal regulations (42 C.F.R. Part 2) and/or Connecticut state law and cannot be further disclosed without my written consent. I further understand that this authorization will expire two years from the date I sign the authorization. I may revoke this authorization in writing at any time; however, any revocation will not be retroactive for information disclosures that have already occurred.

Client Signature:_____ **Date:**_____

Printed Name:_____

NOTICE TO RECIPIENT OF INFORMATION

All or a portion of this information may have been disclosed to you from records protected by Federal and/or Connecticut state law which prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law(s). A general authorization for the release of medical or other information is NOT sufficient for this purpose. In addition, Federal rules (42 C.F.R. Part 2) restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

12/30/2025 JG

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Note: If you are a legal guardian or representative, you must attach a copy of your legal authorization to represent the member and complete the following:

Signature of Guardian/Representative:_____ **Date:**_____
Print:_____ **Legal Authority:**_____

NOTICE TO RECIPIENT OF INFORMATION
All or a portion of this information may have been disclosed to you from records protected by Federal and/or Connecticut state law which prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law(s). A general authorization for the release of medical or other information is NOT sufficient for this purpose. In addition, Federal rules (42 C.F.R. Part 2) restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.