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 on completion of this authorization.

NAME (LAST, FIRST): ____ DATE OF BIRTH: ________________

I hereby authorize the agencies listed below 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	____Alcohol/substance treatment	____HIV/AIDS	____Other (indicate here)	_____ All of the above

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

__AIDS Project New Haven
__Amtrak Police
__Beth-El Center
__BHCare
__Bridges Healthcare
__Career Resources/STRIVE
__Christian Community Action
__City of New Haven
__Columbus House
__Community Action Agency of New Haven
__Community Solutions
__Connecticut Court Support Services Division
__Connecticut Department of Children and Families
__Connecticut Department of Corrections
__Connecticut Department of Housing
__Connecticut Health Network
__Connecticut Mental Health Center
__Connecticut State Dept. of Mental Health and Addiction Services
__Continuum of Care
__Continuum Home Health
__Cornell Scott Hill Health Center
__Connecticut Coalition to End Homelessness
__Downtown Evening Soup Kitchen
__Loaves and Fishes
__Jewish Family Services/CARE
__Easter Seals Goodwill
__Emergency Shelter Management Services
__Fellowship Place
__Integrated Wellness Group
__Jewish Family Services
__Junta FOR Progressive Action
__Leeway New Haven
__Legal Assistance Association
__Liberty Community Services
__Livable Cities Initiative
__Marrakech, Inc
__New Reach
__RM4 Drop In Center
__Spooner House/ACT, Inc
__TEAM, Inc
__The Connection, Inc.
__United Way of Greater New Haven
__United Way of Milford
__Valley YMCA
__Veterans Service Administration
__VNA South Central Connecticut
__Workforce Alliance/American Job Center
__Yale School of Medicine
__Yale-New Haven Hospital
__Youth Continuum
____________________________: Other

I understand that some or all of 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: ____________________________________

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AUTHORIZATION FOR RELEASE OF INFORMATION

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.