Community Care Resources, Inc.

Partnership in Planning

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

(This document is HIPAA compliant)

I HEREBY AUTHORIZE THE USE OR DISCLOSURE OF *PROTECTED HEALTH INFORMATION* ABOUT ME OR THE PERSON LISTED BELOW:

Subject/Individual _____ DOB:_____

(Maiden)

Address _____

Relationship to subject _____

I HEREBY AUTHORIZE THE USE OR DISCLOSURE OF *PROTECTED HEALTH INFORMATION* TO BE RELEASED **FROM/TO**:

Individual/Agency _____

Address _____

I HEREBY AUTHORIZE THE USE OR DISCLOSURE OF *PROTECTED HEALTH INFORMATION* TO BE RELEASED **TO/FROM**:

Individual/Agency Community Care Resources, Inc./Community Care Programs, Inc.
Address 6716 Stone Glen Drive, Middleton, WI 53562

I UNDERSTAND THAT THE SPECIFIC INFORMATION THAT IS USED OR DISCLOSED IS:

_____ Client Information	_____ Recommendation	_____ Intake Assessment
_____ Discharge Summary	_____ Psychiatric Evaluation	_____ Legal Information
_____ Psychological Evaluation	_____ School Attendance	_____ History and Physical
_____ School Grades	_____ Diagnosis	_____ Social History
_____ Drinking/Drug History	_____ Treatment History	_____ Medication History
_____ Work Record	_____ Progress Reports	_____ Lab Results (Specify) _____
_____ Behavioral Information	_____ Photo Release in Agency Publication (for example newsletter publication)	
_____ Other (Specify) _____		

I UNDERSTAND THAT THE SPECIFIC USE AND DISCLOSURE OF THE *PROTECTED HEALTH INFORMATION* IS FOR SERVICES RELATING TO:

__Treatment Foster Home Care __ Outpatient Services __ Other:_____

** THIS AUTHORIZATION EXPIRES **ONE YEAR FROM DATE SIGNED** OR _____**

- I understand that the information used or disclosed may be subject to redisclosure by the person(s) or class of person(s) receiving it and no longer protected by the federal privacy regulations.
- I understand that I may revoke this authorization by notifying *Community Care Resources, Inc.* (*C.C.R.*)/*Community Care Programs, Inc. (C.C.P.)* at 6716 Stone Glen Drive, Middleton, WI 53562 in writing of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any effect on actions taken by *C.C.R./C.C.P., Inc.* in reliance on this authorization.
- I understand that *C.C.R./C.C.P., Inc.* may not condition treatment of me on whether or not I sign this authorization.

_____

Signature of Subject Individual Date

_____/_____ _____

Signature of Person Legally Authorized to Consent for Above Individual Relationship Date

_____

Witness