Community Renewal Team, Inc.
1921 Park Street, Hartford, CT 06106. Ph. 860-951-8770. Fax 860-233-2796.
Service Provider Network

AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

This is to certify that I hereby give my consent to, and authorize:

_____ _____
Agency Staff

to release/obtain a copy of the following information in their possession, including oral disclosure, consisting of but not limited to the following:

(INSTRUCTIONS: Client must initial to signify approval, or write "NO" to signify disapproval. All blanks must be filled in or marked "N/A," not-applicable)

_____Medical records, including HIV related information
_____Psychiatric, psychological, psychotherapy or other counseling records
_____Alcohol and/or drug treatment related information
_____Public assistance
_____Financial
_____Employment
_____CAREWare Data Sharing
_____Academic
_____Other: _____

OF: _____ Date of Birth:_____
Client name

TO:_____
Agency/Staff

_____
Address

In addition, I have been given the opportunity to review an attached list of the provider network of member agencies and also authorize release of information, including oral disclosure between agencies, of the above-cited information to access services within the provider network, as follows:
(Initial to signify approval, or write "NO" to signify disapproval)
_____This agency only
_____Entire network of service providers (**not valid without attached list of service providers**)
_____Other agencies, as noted: _____

All records are confidential. I understand that I may revoke this consent at any time by notifying the above authorized person in writing, except to the extent that information has already been shared. If not revoked by me, I understand that this release is valid for 12 months (365 days) from the date it was signed.

_____ _____
Signature of client or legal representative Date

_____ _____
Witness Date

PROHIBITION ON REDISCLOSURE: This information is disclosed to you from records whose confidentiality is protected by Federal and State law. Regulations prohibit making any further disclosure of this information without the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

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Please initial next to the agencies you wish **Community Renewal Team, Inc.** to share information with:

____AIDS Connecticut, Inc.
110 Bartholomew Avenue
Hartford, CT 06106

____The Hospital of Central CT
100 Grand Street
New Britain, CT 06050

____Community Health Center
33 Ferry Street
Middletown, CT 06457

____Community Health Services
500 Albany Avenue
Hartford, CT 06120

____Community Renewal Team
555 Windsor Street
Hartford, CT 06120

____ University of CT Health Center
263 Farmington Avenue
Farmington, CT 06030

____CT Children's Medical Center
282 Washington Street
Hartford, CT 06106

____St. Francis Hospital (Burgdorf Clinic)
131 Coventry Street
Hartford, CT 06112

____Hartford Hospital (Brownstone Clinic)
79 Retreat Ave
Hartford, CT 06102

____Human Resources Agency
83 Whiting Street
New Britain, CT 06051

____Hartford Gay and Lesbian Health Collective
1841 Broad Street
Hartford, CT 06102

____Latino Community Services
184 Wethersfield Avenue
Hartford, CT 06114

____Health Collective East
64 Church Street
Manchester, CT 06040

____Mercy Housing & Shelter Corporation
211 Wethersfield Avenue
Hartford, CT 06114

____Rockville General Hospital
145 Union Street
Rockville, CT 06066

_____ _____

Client Signature Date