



**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:** \_\_\_\_\_  
Client name

Date of Birth: \_\_\_\_\_

**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

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

\_\_\_\_ The Hospital of Central CT  
100 Grand Street  
New Britain, CT 06050

\_\_\_\_ Human Resources Agency  
83 Whiting Street  
New Britain, CT 06051

\_\_\_\_ Community Health Center  
33 Ferry Street  
Middletown, CT 06457

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

\_\_\_\_ Community Health Services  
500 Albany Avenue  
Hartford, CT 06120

\_\_\_\_ Latino Community Services  
184 Wethersfield Avenue  
Hartford, CT 06114

\_\_\_\_ Community Renewal Team  
555 Windsor Street  
Hartford, CT 06120

\_\_\_\_ Health Collective East  
64 Church Street  
Manchester, CT 06040

\_\_\_\_ University of CT Health Center  
263 Farmington Avenue  
Farmington, CT 06030

\_\_\_\_ Mercy Housing & Shelter Corporation  
211 Wethersfield Avenue  
Hartford, CT 06114

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

\_\_\_\_ Rockville General Hospital  
145 Union Street  
Rockville, CT 06066

\_\_\_\_ St. Francis Hospital (Burgdorf Clinic)  
131 Coventry Street  
Hartford, CT 06112

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Client Signature

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Date