Community Connections
801 PENNSYLVANIA AVENUE, S.E.
SUITE 201
WASHINGTON, D.C. 20003

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I, _____, hereby request that the following information:
(print full name)
Annual physical examination, medical medication prescription information, laboratory results and relevant diagnostic test results. be disclosed by my physician or other medical institution:

_____ (Doctor/Facility Name)
_____ (Address)
_____ (Phone/Fax Number)

To: Community Connections, Inc (Attn. Medical Records Dept.)
801 Pennsylvania Ave SE Suite 201
Washington, DC 20003
Ph. 202-546-1512 Fax: 202-544-5365

In authorizing this disclosure, I understand that this information will be used solely for the purpose of: Assisting the mental health treatment team provide continuous and comprehensive psychiatric care including but not limited to: psychiatry service & medication management, case management/community support services, substance abuse treatment, residential service, and referral & advocacy.

Both now and in the future, and that this authorization for disclosure is limited to information that is now in existence.

I understand that I have a right to inspect my record of mental health information.

I further understand that this information cannot be disclosed or re-disclosed without my authorization.

This consent is subject to revocation in writing at any time. If not revoked by writing, this authorization will expire _____ (no later than 360 days from date below).

_____ _____
Signature of person giving authorization Date

_____ _____
Signature of witness Date

Copies to: (1) consumer; (2) consumer's record; (3) accompany disclosed information
Rev. 10-01

NOTE: This information is not to be used in connection with obtaining life or health insurance.