New London County Coordinated Care Team

New London Coordinated Access Network Housing Placement Team

Adult Probation
AIC, Community Solutions
Alliance for Living (AFL)
American Ambulance
Backus Hospital
Beacon Health Options
Bethsaida Community, Inc.
Catholic Charities
Centro de la Comunidad
Clergy Association
Columbus House
Community Health Center (CHC)
Community Health Network
Covenant Shelter
CT Community Addiction Recovery (CCAR)
CT Department of Housing
CT Dept. of Social Services (DSS)
CT Veterans Administration
Dept. of Children & Families (DCF)
Dept. of Mental Health & Addiction Service (DMHAS)
Eastern Region Mental Health Board
Eastern Regional Service Center
Generations
Hartford Healthcare
Hartford Hospital
Lawrence & Memorial Hospital
Martin House
New London Fire Department
Natchaug Hospital
New London Police Department
New London Human Services
N. L. Homeless Hospitality Center
N. L. Housing Authority
Norwich Human Services
Norwich Police Department
Public Defender's Office
Reliance House
Salvation Army
Safe Futures
SE Council on Alcoholism & Drug Dependence (SCADD)
Social Security Administration
Sound Community Services, Inc.
Southeastern Mental Health Authority (SMHA)
St. Vincent de Paul Place
Stonington Institute
Thames River Community Services
Thames Valley Council for Community Action (TVCCA)
The Connection Inc.
United Community and Family Service (UCFS)
Veterans Administration
VNA of Southeastern CT (VNASC)
Yale-New Haven Hospital

OTHER:_____

Name: _____ Date of Birth: _____ SSN: _____

I authorize the Community Care Team and the CAN Housing Placement Team to release/obtain the following information regarding my case to medical _____, Psychiatric _____, housing _____, alcohol/drug abuse _____, HIV/AIDS _____, criminal record _____, Other _____. (Please check and initial: _____)

This information will be used specifically for the purpose of referral and provision of case management services. I understand that my records are protected under Connecticut Statutes and Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that this consent expires in one (1) year.

_____ _____

Signature of Client Date

_____ _____

Witness Date