

Community Care Associates

Authorization for Use or Disclosure of Protected Health Information

As a client of Community Care Associates, I authorize the CCA care manager to obtain health care information from or share health care information with medical providers, social services providers and/or human services providers. Any of all of them may provide care and services to me in order to improve my safety and well being. Care plans or pertinent findings from the assessment done will be provided as necessary to ensure care is consistent with my current or newly identified medical or social problems that are/may be compromising my ability to live independently.

There may be occasion when the legal system requires a report to be filed with the District Court of Washoe, Carson or Douglas County. In this case, my attorney or the ordering judge will be sent a care plan or report specific to the issues identified in their request/order. My attorney will give me, as the client, a copy of that information if I ask for it.

As CCA does not bill private or federal insurance plans for the services it renders, CCA will not share its information with health plans or insurance companies.

I understand that if the person or entity that receives the information is not a health care provider or a health plan covered by the federal privacy regulation, the information described above may be redisclosed and is no longer protected by these regulations.

I understand that the person I am authorizing to use/disclose the information may receive compensation for doing so.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain services from CCA. I am aware that I may inspect or copy any information used or disclosed under this authorization.

I understand that I may revoke this authorization at any time in writing. Once revocation is requested no further disclosure of information is permitted.

I understand that this authorization expires upon termination of CCA's services.

Signature of client or responsible party _____

Date _____