THE CASA PROJECT, INC.
100 Grove Street
Worcester, MA 01605-2608

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CASA
Court Appointed Special Advocates
FOR CHILDREN

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize _____(agency) _____ (address/telephone number) to use or disclose all information as described below from my healthcare/treatment records to the CASA Project. I understand that if any of this information is protected from release or otherwise considered confidential under any applicable laws or codes, I am waiving those protections in this instance by voluntarily authorizing use or disclosure of the information.

2. Client/Patient name: **Date of Birth:**

Address:

3. Information to be disclosed to:

_____ or any agent or employee of the CASA Project
100 Grove Street Worcester, MA 01605

4 Disclose the following information for dates: _____ to _____ OR as long as the CASA is appointed to the _____ Care and Protection . Docket # _____

Scope or use of disclosure

Health information that may be used or disclosed through this authorization is as follows

- All heath information about me, including the clinical records, created or received by the provider. This information may include:
  - Information pertaining to the identity, diagnosis, prognosis or treatment for alcohol or drug abuse maintained by a substance abuse program or a federally assisted alcohol or drug abuse program.
  - Information regarding AIDS, HIV including, for example, a test for the presence of HIV antibodies or antigens, regardless of whether 1-this test is ordered, performed or reported and 2-the test results are positive or negative
- Other, please specify

_____
_____
_____

The above information is disclosed for legal purposes only.
A photo static copy of this document shall have the same legal effect as an original for the purposes as above referred to. I understand that I may revoke this authorization at any time by requesting such of the above referenced Healthcare facility/professional in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law.

_____ _____

Signature of Patient or Legally Recognized Representative **Date**