Career Opportunity Development, Inc. (CODI)

AUTHORIZATION TO USE OR RELEASE CONFIDENTIAL INFORMATION

By signing this form, I, ____,
Consumer's Name

DOB: _____/_____/__________, Last Four Digits of Social Security Number___ ___ ___ ___,

authorize the release of information maintained by:

Career Opportunity Development, Inc.
901 Atlantic Ave
Egg Harbor City, NJ 08215-1810

My health information may be disclosed to:

Name ____

Address ____

City ____ State _______ Zip Code _______________

For the purpose of: (check all that apply)

☐ **Continuity of Care** ☐ **Service Planning** ☐ **Family Involvement** ☐ **Probation/Parole**
☐ **Other: ____**

Scope and Use of Disclosure:

Information that may be released TO CODI based on this authorization is as follows [Check only those applicable to this disclosure]:

☐ **Discharge Summary** ☐ **Psychiatric Evaluation** ☐ **Social Work History** ☐ **Lab Reports**
☐ **Psychological Evaluation** ☐ **Physical Examination** ☐ **Other: __________________________**
☐ **Information pertaining to testing and/or treatment related for HIV or AIDS and any related conditions**
☐ **Privileged communications between CODI staff and ____________________________________**

Information released FROM CODI based upon this authorization is as follows:
☐ **Discharge Summary** ☐ **Service Plans** ☐ **Other: ____**

Other Important Information

1. **I understand CODI cannot guarantee recipient of this information will not re-disclose information to a third party**
2. **CODI will not re-disclose information obtained by this release.**
3. **I understand I may revoke this authorization in writing at any time. Request to revoke must be submitted in writing to Quality Improvement Coordinator.**
4. **CODI is not responsible for information released prior to revocation.**
5. **Unless otherwise noted this authorization will expire six months from date of authorization or as otherwise stated. Other:______________**

____ ___________________
Signature of Consumer or Guardian **Date**

____ ____________________
Signature of Witness [Title/Relationship to Consumer] **Date**