AUTHORIZATION FOR THE USE AND DISCLOSURE OF INFORMATION
BrazCo Resource Network

  - Your care team will still be able to share your Protected Information if it was created or shared before you submitted your Revocation Notice.

- You have the right to inspect and/or copy (at your expense) your Protected Information, subject to approval of your treatment provider(s). Your Protected Information may still be disclosed when permitted or required by law[2], whether or not you sign or subsequently revoke this Authorization.
- Protected Information disclosed pursuant to this Authorization may be re-disclosed by the recipient and may no longer be protected by federal or state privacy laws. The following statement will accompany your record on CHN MSS: "42 C.F.R. Prohibits unauthorized disclosure of these records."
- A photocopy or electronic copy of this signed Authorization is as effective as the original.

AUTHORIZATION

I hereby authorize and grant permission to the BrazCo Resource Network, to use and disclose my Protected Information to other organizations on the Network for the Purpose. I understand that my care team includes organizations that participate in the Network (a list is available at www.brazconetwork.org. These organizations may include my educators; my past, current, and future treating providers; and law enforcement who provide emergency response service. I understand that by signing below, I am separately consenting to the sharing of Protected Information from each Category, if such information exists.

By signing below, I acknowledge that I have read and that I understand this Authorization form, and my rights with respect to my Protected Information. I also acknowledge a copy of this Authorization form is available upon request.

Signed: Estela B Navarrete

Printed name: Estela B Navarrete

Date: ____________________

Relationship:

__✓__ **Self**