# Resource Connection Network Change of Information Sharing Authorization Form

The purpose of this form is to obtain authorization to change or revoke client consent in the Resource Connection Network system. In the client's profile, user will upload a signed CCF document into the Document Vault and select revoke consent next to the client's consent form. A new consent form must be signed by the client if consent is changing. For questions regarding consent please email Harman Basra, Network Manager, hbasra@capsonoma.org

## Please Indicate the level of consent you would like to share:

I want to participate in RCN Team-Based Care:

- ☐ Yes, with Full RCN Network-wide Authorization.
- ☐ Yes, Only with Team Member Approval.
- ☐ Yes, Only with Client (My) Approval.
- ☐ No, I do not want to participate in RCN Team-Based Care.

Client Name: _____ Date of Birth: _____

Medi-Cal CIN (If known): _____

I wish to change or revoke my authorization. (Please send to your Care Team member)

**Signature of Client or Client's Legal Representative:**

_____ _____/_____/_____

*Month* *Day* *Year*

If signed by Client's Legal Representative, please state your Name and Relationship:

Name of Legal Representative: _____

Relationship: _____