

# NORTH KANSAS CITY POLICE DEPARTMENT

## **CRESA – Citizen Requiring Special Assistance Program**

2020 Howell Street, North Kansas City, MO 64116 | 816.274.6013

### CRESA Contact and Medical Information

#### Citizens Requiring Special Assistance

The CReSA program was established in 1994. This program reaches out to North Kansas City citizens who may have special medical assistance needs. Registering as a CReSA member, ensures awareness on the part of the North Kansas City Police and Fire Departments of special medical assistance North Kansas City citizens may require in the event of a medical response.

To register with the CReSA program, you may print and complete the attached information and HIPAA authorization forms and mail them to:

North Kansas City Police Department  
ATTN: CReSA Registration  
2020 Howell Street  
North Kansas City, MO 64116

You may also acquire these forms at the Communications window in the main lobby of the North Kansas City Police Department.

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## CRSA Contact and Medical Information

Your Name: \_\_\_\_\_

Your Address: \_\_\_\_\_ Apt. # \_\_\_\_\_

Your Home Number: \_\_\_\_\_ Your Cell Number: \_\_\_\_\_

Your Physician's Name: \_\_\_\_\_

Your Physician's Address: \_\_\_\_\_

Your Physician's Phone Number: \_\_\_\_\_

Relative's Name: \_\_\_\_\_

Relative's Address: \_\_\_\_\_

Relative's Phone Number: \_\_\_\_\_ 2<sup>nd</sup> Phone Number: \_\_\_\_\_

Other Responsible Party Name: \_\_\_\_\_

Other Responsible Party Address: \_\_\_\_\_

Other Responsible Party Phone Number: \_\_\_\_\_ 2<sup>nd</sup> Phone Number: \_\_\_\_\_

Your Special Medical Needs or Conditions:

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Pertinent Information You Would Like Emergency Responders to Have:

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Any Additional Information You Would Like to Submit:

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### WAIVER:

Your signature below signifies your acknowledgement that the information provided by you on this form may be disseminated over the North Kansas City Police Department radio to alert emergency responders. Your privacy will be respected at all times and your information will only be provided to those parties responsible for your health and welfare.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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## HIPAA AUTHORIZATION FORM

- I. I hereby authorize the use of disclosure of my protected health information as described below and understand and acknowledge the following:
- I. I am not required to sign this authorization and may, in fact, refuse to sign this authorization. The North Kansas City Police Department will respond to my location, as usual, whether or not this authorization is signed.
  - II. I may inspect or copy the protected health information sought to be used or disclosed in this authorization, as permitted by the federal privacy regulations.
  - III. I have the right to revoke this authorization at any time. My revocation must be in writing and submitted to:  

Glenn Ladd, Chief of Police  
North Kansas City Police Department  
2020 Howell Street  
North Kansas City, MO 64116-3526  
816-274-6013
  - I. If I do revoke this authorization, however, my revocation will not affect any prior actions taken in reliance on my authorization.
  - II. If I have any questions about this authorization, I may contact Chief Glenn Ladd who will provide me with more information about this authorization, or about North Kansas City's privacy practices.

Initials: \_\_\_\_\_

- II. Patient Name: \_\_\_\_\_
- III. This authorization applies to the specific information set forth on page three of the CReSA Application.
- IV. The following persons or organizations are authorized to make the requested use or disclose of my protected health and information identified above:

### Authorized representatives of the City of North Kansas City, Missouri

- V. The following persons or organizations are authorized to receive my protected health information identified above:

### Authorized representatives of the City of North Kansas City, Missouri

- VI. This authorization will expire on \_\_\_\_/\_\_\_\_/\_\_\_\_; or upon the following event:

\_\_\_\_\_

\_\_\_\_\_

I certify that I have read, signed and received a copy of this authorization:

\_\_\_\_\_  
Name of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient (or Patient's Representative)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship of Patient Representative to Patient

\_\_\_\_\_  
Date