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.
CReSA 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: ____________________ 2nd Phone Number: _______________

Other Responsible Party Name: _____________________________________________
Other Responsible Party Address: ___________________________________________
Other Responsible Party Phone Number: ____________________ 2nd Phone Number: ____________

Your Special Medical Needs or Conditions:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Pertinent Information You Would Like Emergency Responders to Have:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Any Additional Information You Would Like to Submit:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

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: ________________________
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:
       Steve Beamer, 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