Consent To Exchange Information

I understand that different agencies provide different services and benefits. Each agency must have specific information in order to provide services and benefits. By signing this form, I am allowing agency staff to exchange certain information so it will be easier for them to work together effectively to provide or coordinate these services or benefits.

FULL PRINTED NAME OF CONSENTING PERSON OR PERSONS:____

FULL PRINTED NAME OF CLIENT:_____________________________________ DATE OF BIRTH: ___________________

CLIENT'S FULL ADDRESS:____

My relationship to the client is:

☐ Self ☐ Parent ☐ Power of Attorney ☐ Guardian ☐ Other Legally Authorized Representative

I want the following confidential information about the client to be exchanged: *(except drug or alcohol abuse diagnoses or treatment information)*

Yes	No		Yes	No		Yes	No	
☐	☐	Assessment Information	☐	☐	Medical Diagnosis	☐	☐	Educational Records
☐	☐	Financial Information	☐	☐	Mental Health Diagnosis	☐	☐	Psychiatric Records
☐	☐	Benefits/Services Needed,	☐	☐	Medical Records	☐	☐	Criminal Justice Records
☐	☐	Planned and/or Received	☐	☐	Psychological Records	☐	☐	Employment Records
☐	☐	Other Information (Write In):_______________						

I want: Hanover CSA Coordinator 12304 Washington Hwy Ashland VA 23005_____________________________

____

And the following other agencies to be able to exchange this information:

☐ Hanover Dept. of Social Services
☐ Hanover Family Assessment & Planning Team
☐ Hanover Community Services Board
☐ Hanover Community Policy & Management Team
☐ Hanover Public Schools & Educational Service Providers
☐ OCS/ Statewide/ local CSA Offices, as applicable
☐ Private Providers: ___________________________________
☐ VA Dept. of Mental Health, Mental Retardation & Substance Abuse
☐ CANS Administrators
☐ Hanover Community Resources/Hanover CASA
☐ Hanover Court Services Unit
☐ Hanover Health Department
☐ Utilization Review Providers
☐ Current Provider(s) listed on FAPT approved/signed IFSP

Are More Agencies Listed on Back? ☐ Yes ☐ No

I want this information to be exchanged ONLY for the following purpose(s):

☐ Service Coordination & Treatment Planning ☐ Eligibility Determination ☐ Other: (Write In):_____________

I want information to be shared: ☐ Written Information ☐ In Meetings or By Phone ☐ Computerized Data

Unless otherwise revoked, this Consent/Authorization will expire: __________________________

I can withdraw this consent at any time by telling the referring agency. This will stop the listed agencies from sharing information after they know my consent has been withdrawn. I have the right to know what information about me has been shared, and why, when, and with whom it was shared. If I ask, the agency will provide me this information. I want all the agencies to accept a copy of this form as a valid consent to share information. If I do not sign this form, information will not be shared and I will have to contact each agency individually to give them information about me that they need.

SIGNATURE (S): ____ Date: ______________

CONSENTING PERSON(S)

PERSON EXPLAING FORM: ____ Date: ______________

Revised 7/01/2016

HANOVER COMMUNITY SERVICES
CONSENT TO DISCLOSURE AND AUTHORIZATION
FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

I, ____, **authorize** VICAP Screener /Hanover CSB staff/______________
[Full Name of Person Consenting to Disclosure or Authorizing Release of PHI] [Print Name of Person(s) or Class(es) of Persons, or Hanover CSB]

of the **Hanover County Community Services Board (HCCSB) To disclose to:** X **Exchange with:** X **Obtain from:** X

Name of person or agency: Kara Brooks, CSA office and Hanover FAPT **Address:** 12304 Washington Hwy Ashland, VA 23005

The information specified below concerning the treatment:____
[Print Client's Full Name]

Information to be disclosed *[check all that apply]:*

- ☐ Treatment Plan
- ☐ Summary of Services Received
- ☐ Summary of Participation/ Attendance
- ☐ Medication(s) Prescribed
- ☐ Diagnosis
- ☐ Evaluation/Assessment
- ☐ Psychological Evaluation
- ☐ Progress Notes
- ☐ Social History
- ☐ Substance Abuse/Use History
- ☐ Family/Social History
- ☐ Legal Status/History
- ☐ Employment History/Performance
- ☐ Urine Drug Screen Results
- ☐ School Results
- ☐ Case Closing Summary
- ☐ Other: VICAP Screening

Disclosure may include *[check all that apply]*:
____Alcohol/ Drug Abuse Information
____AIDS or HIV related information
____Other Infectious Diseases (such as TB, Hepatitis, etc.)

Purpose of disclosure:
____ Assessment
___ Follow-up care
____ Ongoing Treatment
____ Other [*specify*]: VICAP____________________

As the person signing this **Consent to Disclosure and Authorization for the Release of Protected Health Information**, I understand that I am giving permission for HCCSB to release or obtain and use confidential health information. I understand that treatment, payment, enrollment or eligibility for benefits is not affected by signing this form. I understand that I may refuse to sign this Authorization. I also understand that the information disclosed may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations and may no longer be protected by state law. A copy of this Authorization will be included in the client's service (medical) record.

I understand that I may revoke this Consent/Authorization at any time, except to the extent that action has already been taken in reliance on it. I will notify HCCSB in writing of my desire to revoke this Consent/Authorization; my revocation is not effective until delivered in writing to the person in possession of the client's medical records.

This Consent/Authorization will automatically expire upon termination of service in the Agency.

Unless otherwise revoked, this Consent/Authorization will expire in: _____ 90 Days, _____ 365 Days (one year).

____ ____
[Client's / Representative's Signature] ** [Date]

**** Authorization must be signed by the Client.** If the signature is not that of the Client, check one of the following:

☐ Client is a Minor ☐ Client is unable to sign for the following reason(s):______________________________

Basis of Representative's authority to sign Authorization on behalf of the Client: ______________________________

____ ____
[Staff Witness to Signature] [Date]

Note: *This information may be protected by federal regulations concerning alcohol and drug abuse patient records (42 CFR, Subchapter A, Part 2), which prohibit recipient from making any further disclosure of alcohol or substance abuse treatment information unless further disclosure is expressly permitted by written authorization of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for release of medical or other information is Not sufficient for this purpose these regulations also restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.*

SEND TO THE ATTENTION OF: VICAP Screener/____________________,Hanover County Community Services Board at 8475 Bell Creek Road, Mechanicsville, VA 23116 or 12300 Washington Hwy, Ashland VA 23005