

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
<input type="checkbox"/>					
<input type="checkbox"/>					
<input type="checkbox"/>					
<input type="checkbox"/>					
<input type="checkbox"/>					
<input type="checkbox"/>					

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 CANS Administrators
- Hanover Family Assessment & Planning Team Hanover Community Resources/Hanover CASA
- Hanover Community Services Board Hanover Court Services Unit
- Hanover Community Policy & Management Team Hanover Health Department
- Hanover Public Schools & Educational Service Providers Utilization Review Providers
- OCS/ Statewide/ local CSA Offices, as applicable Current Provider(s) listed on FAPT approved/signed IFSP
- Private Providers: _____ Are More Agencies Listed on Back? Yes No
- VA Dept. of Mental Health, Mental Retardation & Substance Abuse

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 This will stop the listed agencies from sharing information after they know my consent has been withdrawn.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 EXPLAINING FORM: _____ Date: _____