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:

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 - 12304 Washington Hwy Ashland VA 23005_____

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

Hanover Dept. of Social Services
Hanover Family Assessment & Planning Team (FAPT)
Hanover Community Services Board
Hanover Community Policy & Management Team (CPMT)
Hanover Public Schools and Educational Services Providers
OCS/ Statewide/ local CSA Offices, as applicable
Private Providers: _____
VA Dept. of Mental Health and Developmental Services
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 upon FAPT case closure, or on_____

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 This will stop the listed agencies from sharing information after they know my consent has been withdrawn.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 7/01/2020