CONSENT TO EXCHANGE INFORMATION

I understand that different agencies provide different services and benefits. Each agency must have specific information to provide services and benefits. By signing this form, I allow agencies to use and exchange certain information about me, including information in an electronic database, so it will be easier for them to work together efficiently to provide or coordinate these services or benefits. This includes allowing Clarke County CSA to provide pertinent information to a receiving locality in Virginia, should I move while receiving services.

I, _____, am signing this form for:
FULL PRINTED NAME OF AUTHORIZING PERSON OR PERSONS

_____
FULL PRINTED NAME OF INDIVIDUAL

_____
INDIVIDUAL'S ADDRESS *INDIVIDUAL'S BIRTH DATE* *INDIVIDUAL'S SSN*

My relationship to the individual is: ☐ Self ☐ Parent ☐ Power of Attorney ☐ Guardian ☐ Other Legally Authorized Representative

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I want the following confidential information about the individual 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, Planned, and/or Received	☒	☐	Medical Records	☒	☐	Criminal Justice Records
			☒	☐	Psychological Records	☒	☐	Employment Records
☒	☐	Substance Abuse Records				☒	☐	All of the Above

Other Information (write in):_____

I want the following entities to be able to use and exchange this information among themselves: Participants in the Child and Family Team meeting, CSA office of Clarke County or locality of residence, Clarke County CPMT, Clarke County FAPT, and/or:

YES	NO		YES	NO	
☒	☐	CCAP	☒	☐	National Counseling Group
☒	☐	Child Development Clinic	☒	☐	Northwestern CSB
☒	☐	Counselor/Therapist:_____	☒	☐	Physician:_____
☒	☐	Department of Social Services	☒	☐	Winchester Public Schools
☒	☐	Grafton Integrated Health Network	☒	☐	Clarke County Public Schools
☒	☐	Connected Communities, Inc	☒	☐	Winchester Community Mental Health
☒	☐	Virginia Health Department	☒	☐	Other:_____

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

☒ Service Coordination and Treatment Planning ☒ Eligibility Determination ☐ Other: _____

I want this information to be shared by the following means: (check all that apply)

☒ Written Information ☒ In Meetings ☒ By Phone ☒ Computerized Data ☐ Fax

I want to share additional information received after this authorization is signed: ☒ Yes ☐ No

This authorization is effective: _____*DATE*

This authorization is good until: ☒ My service case is closed. ☐ Other: _____

I can withdraw this authorization at any time by telling the referring agency. The listed agencies must stop sharing information after they know my authorization 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, each agency will show me this information. I want all agencies to accept a copy of this form as valid authorization 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 information about me that is needed.** However, I understand that treatment and services cannot be conditioned upon whether I sign this authorization. There is a potential for information disclosed pursuant to this authorization to be re-disclosed by the recipient and not be subject to the HIPAA Privacy Rule.

Signature(s): _____ Date: _____
AUTHORIZING PERSON OR PERSONS

Person Explaining Form: _____
Name *Address* *Phone Number*

Witness (If Required):_____
Signature *Address* *Phone Number*

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