CONSENT TO EXCHANGE INFORMATION

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

I, _____, am signing this form for
(Full printed name of consenting person(s)

_____
(Full printed name of client)

_____
(Client's Address) (Client's Birth Date) (Client's SSN-Optional)

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 (except drug or alcohol abuse diagnoses or treatment information) 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

I want

_____
(Name and Address of Referring Agency and Staff Contact Person)

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

Chesterfield County Family Assessment & Planning Team (FAPT), Colonial Heights FAPT, Chesterfield/Colonial Heights Community Policy and Management Team (CPMT) members and member agencies to include the Community Services Board, Department of Social Services, Public Schools, Juvenile Court Service Unit and Health Department, FAPT/CPMT parent representatives and any prospective/actual vendor/agency providing services outlined on the service plan developed by these teams and myself.

I want this information to be exchanged ONLY for the following purpose(s): ☐ Service Coordination and Treatment Planning
☐ Eligibility Determination Other: _____

Information may be exchanged by written, computerized and verbal methods.

This consent is good until _____ or when FAPT involvement ends. 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 This will stop the listed agencies from sharing information after they know my consent has been withdrawn.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, each agency will show 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 the information that they need.

Signature(s): _____ _____
(Consenting Person or Persons) (Date)

Person Explaining Form: _____
(Name) (Title) (Phone Number)

Witness (if required): _____
(Signature) (Address) (Phone Number)