CONSENT TO EXCHANGE INFORMATION

I understand that different agencies provide services and benefits. Each agency must have specific information in order to provide services and benefits. By signing this form, I am allowing agencies to exchange 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

Client's Name & Address

Please Print: ____
Name

____
Street Address

____
Town,State,Zip

*Client's Birthdate:*_______________

Client's Social Security Number: ________________________________

My relationship to client is : ☐ *Self* ☐ *Parent* ☐ *Power of Attorney* ☐ *Guardian* ☐ *Other Legal Representative*

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

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):

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

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

Court Services Unit ***Mental Health Facilities*** ***Health Department***
Public Schools ***Department of Social Services***
Other Agencies:____

I want this information to be exchanged ONLY for the following purposes:
______ Service Coordination and Treatment Planning

______ Eligibility Determination

Other (please complete):____

I want information to be shared (check all that apply):

_______ Written Information _____ In Meetings or by Phone _____ Computerized Data

I want to share additional information after this consent is signed: ____ Yes ____ No

This Consent is Good Until….

- *This consent is good until the case closes to CSA.*
- *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 This will stop the listed agencies from sharing information after they know my consent has been withdrawn.*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 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 that they need.*

Signature: ____ ***Date:*** __________________
Consenting Person or Guardian

Person Explaining this form: ____

Title:______________________***Phone #:***________________________