**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 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, Click or tap here to enter text. , am signing this form for

(*FULL PRINTED NAME OF CONSENTING PERSON OR PERSONS)*

Click or tap here to enter text.

*(FULL PRINTED NAME OF CLIENT)*

Click or tap here to enter text. Click or tap to enter a date. Click or tap here to enter text.

*.(CLIENT’S ADDRESS) (CLIENTS BIRTHDATE) (CLIENT SS # 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** |  |
| x | 🞎 | Assessment Information | x | 🞎 | Medical Diagnosis | x | 🞎 | Educational Records |
| x | 🞎 | Financial Information | x | 🞎 | Mental Health Diagnosis | x | 🞎 | Psychiatric Records |
| x | 🞎 | Benefits/Services Needed, Planned, and/or received | x  x | 🞎  🞎 | Medical Records  Psychological Records | x  x | 🞎  🞎 | Criminal Justice Records  Employment Records |
|  |  | Other information write in: |  |  |  |  |  |  |

I want: Click or tap here to enter text.

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

**Any agency whose information would enhance the possibility of employment.**

*Are More Agencies Listed on Back? YES* 🞎 *NO* x

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

x Service Coordination and Treatment Planning x Eligibility Determination x Employment Verification

|  |  |
| --- | --- |
| Other (write in): |  |

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

x Written Information x In Meetings or by Phone x Computerized Data

I want to share additional information received after this consent is signed: x YES 🞎 NO

|  |  |
| --- | --- |
| This consent is good until: | **Completion of Program** |

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 information about me that they need.***

Signature(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(*Consenting person or persons)*

Person Reviewing Form: Name and Title Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_