

# CONSENT TO RELEASE / EXCHANGE INFORMATION

## Stafford County At-Risk Youth and Family Services

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 services or benefits.

I, \_\_\_\_\_, am signing this form for  
(FULL PRINTED NAME OF CONSENTING PERSON OR PERSONS)

\_\_\_\_\_  
(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 to be released/exchanged (please circle Y for Yes, N for No):

<input type="checkbox"/> Y <input type="checkbox"/> N Assessment Information	<input type="checkbox"/> Y <input type="checkbox"/> N Social History	<input type="checkbox"/> Y <input type="checkbox"/> N Financial Information
<input type="checkbox"/> Y <input type="checkbox"/> N Medical Diagnosis	<input type="checkbox"/> Y <input type="checkbox"/> N Mental Health Diagnosis	<input type="checkbox"/> Y <input type="checkbox"/> N Education Records
<input type="checkbox"/> Y <input type="checkbox"/> N Medical Records	<input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric Records	<input type="checkbox"/> Y <input type="checkbox"/> N Criminal Justice Records
<input type="checkbox"/> Y <input type="checkbox"/> N Psychological Records	<input type="checkbox"/> Y <input type="checkbox"/> N Discharge / Treatment Summary	<input type="checkbox"/> Y <input type="checkbox"/> N Employment Records
<input type="checkbox"/> Y <input type="checkbox"/> N Benefits / Services needed, planned, and/or received	Other Information: _____	

I want (name of staff contact person and address of referring agency) \_\_\_\_\_

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

Community Services Board  Court Service Unit  Health Department  DSS  
 Schools  CSA offices and teams (FAPT and CPMT)  Law Enforcement  
 Other(s): \_\_\_\_\_

I want this information to be released/exchanged ONLY for the following purpose(s) (check all that apply):

Service coordination and treatment planning  Eligibility determination  Evaluating outcomes or impact of services

Other (write in): \_\_\_\_\_

I want information to be shared by (check all that apply):  Written information  In meetings or by phone  Computerized data

I want to share additional information received after this consent is signed:  yes  no

### **This consent is good until the youth/family has been discharged from CSA funded services**

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 explaining form: \_\_\_\_\_  
(NAME) (TITLE) (PHONE NUMBER)

Witness (if required): \_\_\_\_\_  
(SIGNATURE) (ADDRESS) (PHONE NUMBER)

Stafford CSA CONSENT TO RELEASE / EXCHANGE INFORMATION FORM

FOR AGENCY USE ONLY

FULL PRINTED NAME OF CLIENT: \_\_\_\_\_

Consent has been:

\_\_\_\_\_ Revoked in entirety

\_\_\_\_\_ Partially revoked as follows:

Notification that consent was revoked was by:

\_\_\_\_\_ Letter (attach copy)

\_\_\_\_\_ Telephone

\_\_\_\_\_ In person

Date revocation request was received: \_\_\_\_\_

Agency representative receiving request:

Agency representative's full name and title: \_\_\_\_\_

Agency address and telephone number: \_\_\_\_\_