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):

Y N Assessment Information
Y N Social History
Y N Financial Information
Y N Medical Diagnosis
Y N Mental Health Diagnosis
Y N Education Records
Y N Medical Records
Y N Psychiatric Records
Y N Criminal Justice Records
Y N Psychological Records
Y N Discharge / Treatment Summary
Y N Employment Records
Y 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 This will stop the listed agencies from sharing information after they know my consent has been withdrawn.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)

9/12/17