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.

(FULL PRINTED NAME OF CONSENTING PERSON OR PERSONS)

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**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:

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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</tr>
<tr>
<td>[ ] Assessment Information</td>
<td>[ ] Medical Diagnosis</td>
<td>[ ] Educational Records</td>
<td></td>
</tr>
<tr>
<td>[ ] Financial Information</td>
<td>[ ] Mental Health Diagnosis</td>
<td>[ ] Psychiatric Records</td>
<td></td>
</tr>
<tr>
<td>[ ] Benefits / Services Needed Planned, and/or Received</td>
<td>[ ] Medical Records</td>
<td>[ ] Criminal Justice Records</td>
<td></td>
</tr>
<tr>
<td>[ ] Other Information (write in):</td>
<td>[ ] Psychological Records</td>
<td>[ ] Employment Records</td>
<td></td>
</tr>
</tbody>
</table>

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I want:

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

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

- [ ] Service Coordination and Treatment Planning
- [ ] Eligibility Determination
- [ ] Other (write in):

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

- [ ] Written Information
- [ ] In Meetings or By Phone
- [ ] Computerized Data

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I want to share additional information received after this consent is signed: ⬜YES ☐ NO

This consent is good until:

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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.

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Signature(s):

CONSENTING PERSON OR PERSONS

Date:

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Person Explaining Form:

(Consenting Person or Persons)

(doctype)

Phone Number

Witness (If Required):

(Signature)

(Address)

(Phone Number)

3-14-92

032-01-005
UNIFORM CONSENT TO EXCHANGE INFORMATION FORM

FULL PRINTED NAME OF CLIENT: ________________________________

<table>
<thead>
<tr>
<th>FOR AGENCY USE ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>CONSENT HAS BEEN:</td>
</tr>
<tr>
<td>☐ Revoked in entirety</td>
</tr>
<tr>
<td>☐ Partially revoked as follows:</td>
</tr>
</tbody>
</table>

| NOTIFICATION THAT CONSENT WAS REVOKED WAS BY: |
| ☐ Letter (Attach Copy) ☐ Telephone ☐ In Person |

| DATE REQUEST RECEIVED: | |

| AGENCY REPRESENTATIVE RECEIVING REQUEST: |
| (AGENCY REPRESENTATIVE’S FULL NAME AND TITLE) |
| (AGENCY ADDRESS AND TELEPHONE NUMBER) |

5-14-92
032-01-005