

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, _____, 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 (except drug or alcohol abuse diagnoses or treatment information) to be exchanged:

Yes	No	Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other Information (write in): _____

I want: _____

(NAME AND ADDRESS OF REFERRING AGENCY AND STAFF CONTACT PERSON.)

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

Are More Agencies Listed on Back? YES NO

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

- Service Coordination and Treatment Planning
- Eligibility Determination

Other (write in): _____

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 received after this consent is signed: YES NO

This consent is good until: _____

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 This will stop the listed agencies from sharing information after they know my consent has been withdrawn.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)

UNIFORM CONSENT TO EXCHANGE INFORMATION FORM

FULL PRINTED NAME OF CLIENT: _____

FOR AGENCY USE ONLY

CONSENT HAS BEEN:

- Revoked in entirety
- Partially revoked as follows:

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,