KING GEORGE COUNTY 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, [*FULL PRINTED NAME OF CONSENTING PERSON(S)*] _____, am signing this form for:

FULL PRINTED NAME OF CLIENT: _____

CLIENT'S ADDRESS: _____

CLIENT'S BIRTH DATE: _____ *CLIENT'S SSN:* _____

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 exchanged:

YES	NO		YES	NO		YES	NO	
☒	☐	Assessment Information	☒	☐	Medical Diagnosis	☒	☐	Education Records
☒	☐	Financial Information	☒	☐	Mental Health Diagnosis	☒	☐	Psychiatric Records
☒	☐	Benefits/Services Needed, Planned, and/or Received	☒	☐	Medical Records	☒	☐	Criminal Justice Records
			☒	☐	Psychological Records	☒	☐	Employment Records
						☒	☐	Substance Abuse Records

Other information (please specify): _____

I authorize the following agencies to be able to exchange this information:

King George Social Services, King George Health Department, King George County Schools, RACSB, 15TH District Court Services Unit, King George FAPT and CPMT, King George CSA Coordinator, Others: Selected Vendors per IFSP, Office of Children's Services/Statewide/Local CSA Offices as applicable.

I want this information to be exchanged ONLY for the following purposes:

☒Service Coordination and Treatment Planning ☒Eligibility Determination

☐ Other (specify): _____

I want information to be shared (check all that apply):
☒Written Information ☒In meetings or by phone ☒ All Electronic Data ☒ Faxed Data

I want to share additional information received after this consent is signed: ☒Yes ☐ No

This consent is good until: revoked in writing.

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 This will stop the listed agencies from sharing information after they know my consent has been withdrawn.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): **X**_____
Consenting Person(s)

Date: **X**_____

Person Explaining Form: ___Robin Thompson___CSA Coordinator__540-252-5090_____
(*Name)* *(Title*) (*Telephone Number*)