



CONSENT TO EXCHANGE INFORMATION

I understand that different agencies provide different service 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 DOB) (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
X	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	X	<input type="checkbox"/>
X	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
X	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	X	<input type="checkbox"/>

With NORTHERN VIRGINIA FAMILY SERVICE; VEHICLES FOR CHANGE PROGRAM

And the following other agencies to be able to exchange this information:
 Please mark the agencies that you have received services from if you agree to this exchange of information.

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

Are more agencies listed on the back? Yes No

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

Service Coordination and Treatment Planning Eligibility Determination Self-Sufficiency Planning

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: 12 months from date below
- I can withdraw this consent at any time by telling NVFS. 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, 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