GVPHC Services Coordinated And Assessment Network (SCAAN)

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 on behalf of ____________________________

____

(CLIENT'S ADDRESS) *(CLIENT'S DATE OF BIRTH)* *(CLIENT'S SSN)*

My relationship to the client is: ☐ Self ☐ Parent ☐ Power of Attorney ☐ Guardian ☐ Other Legally Authorized Representative

Please see reverse side for additional parties included in this Consent to Exchange Information.

I want the following confidential information to be exchanged:

Yes/No	Yes/No	Yes/No
☐ ☐ Assessment Information	☐ ☐ Medical Diagnosis	☐ ☐ Educational Records
☐ ☐ Financial Information	☐ ☐ Mental Health Diagnosis	☐ ☐ Psychiatric Records
☐ ☐ Benefits/Services Needed, Planned, and/or Received	☐ ☐ Medical Records	☐ ☐ Criminal Justice Records
	☐ ☐ Psychological Records	☐ ☐ Employment Records

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:

3e Restoration
ACCESS Aids/Candii, Inc.
Avalon
Colonial Behavioral Health
Colonial Community Corrections
Five Loaves Food Pantry
Gordon Wellness, LLC
Hampton City Schools
Hampton Dept. of Human Services
Hampton- Newport News Community Services Board
Hampton Probation and Parole
Hampton Roads Community Action Program, Inc.
Hampton VA Medical Center
H.E.L.P, Inc.
James City Count Dept. of Human Services
James City County Housing
LINK of Hampton Roads
Menchville House Ministries
Newport News Dept. of Human Services
Newport News Sheriff's Office
Newport News Police Department
The Planning Council
The Salvation Army, Peninsula
The Salvation Army, Williamsburg
THRIVE Peninsula
Transitions Family Violence Services
Unison Mental Health
United Way of Greater Williamsburg
US. Dept. of Veterans Affairs
VA Dept. of Corrections
VA Employment Commission
VA Veteran & Family Support
Williamsburg Dept. of Human Services
Williamsburg House of Mercy
York-Poquoson Social Services
OTHER (Write In & Initial):

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

☐ Service Coordination and Treatment Planning ☐ Continued Medical/Mental Health Treatment

☐ Eligibility Determination ☐ Other (write in): ____

I understand that this information may be shared as written information and/or fax, in meetings or by telephone, and as computerized data/HMIS entry. I understand this release will be effective for a period of three (3) years from the date of execution.

I understand that my records are protected by state and federal confidentiality laws and cannot be disclosed without my written consent. I authorize the release of personal health information regarding my treatment to the aforementioned agencies. This authorization includes information related to alcohol and drug abuse, mental health treatment, except psychotherapy notes, and confidential HIV related information. HIV, alcohol or drug information will not be res-disclosed without my written consent. I understand that I may revoke this authorization at any time, except to the extent that those receiving this authorization have already acted in reliance upon it. Signing this release is voluntary. My treatment or access to services will not be conditioned on my authorization of disclosure. 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: ______________________

(Client/Consenting Person Signature)

Person Explaining Form: ____

(Name) (Title) (Phone Number)

Additional Parties Named in the Release of Information

Name: ______________________________ Relationship: _______________________
DOB: ______________________________ Last 4 SS #: _____________________

Name: _______________________________Relationship: ________________________
DOB: _______________________________ Last 4 SS #: _____________________

Name: ______________________________ Relationship: _______________________
DOB: ______________________________ Last 4 SS #: _____________________

Name: _______________________________Relationship: ________________________
DOB: _______________________________ Last 4 SS #: _____________________

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DOB: ______________________________ Last 4 SS #: _____________________

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DOB: _______________________________ Last 4 SS #: _____________________

Name: ______________________________ Relationship: _______________________
DOB: ______________________________ Last 4 SS #: _____________________

Name: _______________________________Relationship: ________________________
DOB: _______________________________ Last 4 SS #: _____________________

Client Signature: ____Date: ________

Spouse Signature (*If Applicable*): ____Date: ________

Agency Witness: ____Date: _________

FOR AGENCY USE ONLY

CONSENT HAS BEEN:

- ❍ Revoked in entirety
- ❍ Partially revoked as follows:____

NOTIFICATION THAT CONSENT WAS REVOKED WAS BY:

❍ Letter (Attached Copy) ❍ Telephone ❍ In Person

DATE REQUEST RECEIVED:

AGENCY REPRESENTATIVE RECEIVING REQUEST:

____

(Agency Representative's Full Name and Title)

____

(Agency Address and Telephone Number)

Revised October 31, 2016