CITY OF ALEXANDRIA, VIRGINIA
AUTHORIZATION TO USE AND EXCHANGE INFORMATION

I understand that different agencies provide different services and benefits. Each agency must have specific information to provide services and benefits. By signing this form, I allow agencies to use and exchange certain information about me, including information in an electronic database, so that it will be easier for them to work together efficiently to provide or coordinate these services or benefits.

Client's Name ________________________ DOB____________ SSN (Optional) ____________

Client's Address ________________________ City____________ State______ Zip Code __________

Name of Authorizing Person or Persons ____

Relationship to Client: ☐ Self ☐ Parent ☐ Power of Attorney ☐ Guardian ☐ Other Legally Authorized Representative

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I want the following confidential information about the client to be disclosed/exchanged where allowable by law or regulation (*Check all that apply*):

- ☐ Assessment Information
- ☐ Financial Information
- ☐ Benefits/Services Needed, Planned, and/or Received
- ☐ Medical Diagnosis
- ☐ Other (write in) ________________________
- ☐ Mental Health Diagnosis
- ☐ Medical Records
- ☐ Mental Health Records
- ☐ Psychological Records
- ☐ Psychiatric Records
- ☐ Substance Abuse Records (*see also page 2*)
- ☐ Educational Records
- ☐ Employment Records
- ☐ Juvenile Justice Records
- ☐ Child Welfare Services Record Information

<u>Most Recent Records:</u> ☐ Yes ☐ No If No, Specify Date Range: ________________________

<u>Release the above information to</u>: Agency Name ________________ Staff Contact Name ______________

Address ________________________ City ______________ State _____ Zip __________

Phone ______________ Email ________________________ Fax ________________

<u>I want the following entities to be able to use and exchange the above information among themselves:</u>

Yes (*Check all that apply*)	***Write in Name of Program/Team***
☐ Alexandria City Public Schools	____________
☐ Alexandria Court Service Unit/ Virginia DJJ	____________
☐ ADCHS – Adult Behavioral Health (CSB)	____________
☐ ADCHS – Center for Economic Support	____________
☐ ADCHS – Child and Family Behavioral Health (CSB)	____________
☐ ADCHS – Child Welfare (including CPS records information)	____________
☐ ADCHS – Other Adult Services	____________
☐ Alexandria Family Assessment & Planning Team (FAPT)	____________
☐ Alexandria Health Department	____________
☐ Alexandria Police Department	____________
☐ Hospital	____________
☐ Physicians	____________
☐ Office of Children's Services/local CSA Offices (as needed)	____________
☐ OTHER (write in)	____________
☐ OTHER (write in)	____________

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

☐ Service Coordination and Treatment Planning ☐ Eligibility Determination ☐ Other: ______________

I understand that information will be shared by written, verbal, faxed and/or via computerized methods: ☐ Yes ☐ No

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

This form expires on: ☐ Specified date__________ ☐ One year from date signed ☐ Date of case closure (not for CSB)

<u>I can cancel</u> this form at any time by telling the referring agency representative in writing. I understand that the consent includes information already in my file and information added to it until the expiration date. <u>I have the right</u> to know what information about me has been shared. <u>I have the right</u> to know why and when it was shared, and who received the information. <u>If I ask</u>, each agency will show me this information. <u>I want all</u> agencies to accept a copy of this form as my permission to share information. **If I do not sign this form, information will not be shared and I will have to contact each agency to give information about me that is needed.** <u>I understand</u> that an agency cannot require me to sign this form to get services. Agencies that receive information because of this form might share it with others, as allowed by law.

Signature(s): ________________________________ **Date:** ______________
(AUTHORIZING PERSON OR PERSONS)

Person Explaining Form: ____
(NAME) ***(ADDRESS)*** ***(PHONE NUMBER)***

Witness *(If Required)*: ____
(SIGNATURE) ***(ADDRESS)*** ***(PHONE NUMBER)***

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Sign below ONLY if authorizing release of Substance Abuse Records

I understand that substance abuse treatment records are protected by the Federal Drug & Alcohol Confidentiality Regulations (42 CFR, Part 2). Someone who receives substance abuse treatment records cannot share them with anyone else unless I allow it in writing, or if regulations in 42 CFR, Part 2, allows it. This consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance upon it.

Signature: ______________________________________ **Date:** _______________
(AUTHORIZING PERSON OR PERSONS)

Full Printed Name of Client: ____

FOR AGENCY USE ONLY

AUTHORIZATION HAS BEEN:

☐ Revoked in its entirety

☐ Partially revoked as follows:____

NOTIFICATION THAT AUTHORIZATION WAS REVOKED WAS BY:

☐ Letter (Attach Copy) ☐ Telephone ☐ In Person

DATE REVOCATION RECEIVED: __________________

AGENCY REPRESENTATIVE RECEIVING REVOCATION:

Agency Name_________________________ Agency Address____

Agency Representative's Full Name and Title____________________________________ Phone Number_____________

[INTENTIONALLY LEFT BLANK]