CONSENT TO EXCHANGE INFORMATION

VDH VIRGINIA DEPARTMENT OF HEALTH

I understand that different agencies provide different services and benefits. Each Virginia agency must have information in order to provide services. 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(s)

_____
(Full printed name of client)

_____
(Client's Address) (Client's Birth Date)

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	
☐	☐	Assessment Information	☐	☐	Medical Diagnosis
☐	☐	Benefits/Services Needed Planned and/or Received	☐	☐	Medical Records
			☐	☐	Financial Information

I want

(Name and Address of Referring Agency and Staff Contact Person)

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

The Virginia Bleeding Disorders Program of the Virginia Department of Health

I want this information to be exchanged ONLY for the following purpose(s):
☐ Service Coordination and Treatment Planning ☐ Eligibility Determination

Information may be exchanged by written, computerized and verbal methods.

This consent is good for one year from the date of signature. 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 This will stop the listed agencies from sharing information after they know my consent has been withdrawn.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 the information that they need.

Signature(s): _____ _____
(Consenting Person or Persons) (Date)

Person Explaining Form: _____
(Name) (Title) (Phone Number)

Witness (if required): _____
(Signature) (Address) (Phone Number)