

CONSENT TO EXCHANGE INFORMATION-SWVTC RCSC

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 for  
(FULL PRINTED NAME OF CONSENTING PERSON OR PERSONS)

\_\_\_\_\_  
(FULL PRINTED NAME OF CLIENT)

\_\_\_\_\_  
(CLIENT'S ADDRESS)

\_\_\_\_\_  
(CLIENT'S BIRTH DATE)

\_\_\_\_\_  
(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
<input type="checkbox"/>					
<input type="checkbox"/>					
<input type="checkbox"/>					
<input type="checkbox"/>					

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:

Are more agencies listed on back? Yes  No

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

Service Coordination and Treatment Planning  Eligibility Determination

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: \_\_\_\_\_

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 This will stop the listed agencies from sharing information after they know my consent has been withdrawn.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): \_\_\_\_\_ Date: \_\_\_\_\_  
(Consenting person or persons)

Person Explaining Form: \_\_\_\_\_  
(Name) (Title) (Phone Number)

Witness (If required): \_\_\_\_\_  
(Signature) (Address) (Phone Number)

UNIFORM CONSENT TO EXCHANGE INFORMATION FORM

FULL PRINTED NAME OF CLIENT: \_\_\_\_\_