# Norfolk Children's Services Act Office
# Consent to Exchange Information

I understand that different agencies provide 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) (Printed Name of Client)

______________________________________________________________________________
(Client's Address) (Client's Date of Birth) (Client's SSN)

| **My relationship to the client is:** | ☐ Self ☐ Guardian ☐ Power of Attorney ☐ Parent ☐ Other Legally authorized Representative |
|---|---|

| **I want the following confidential information about the client to be exchanged:** | | | |
|---|---|---|---|
| ☐ Assessment Information | ☐ Medical Diagnosis | ☐ Educational Records | ☐ Financial Information |
| ☐ Mental Health Diagnosis | ☐ Psychiatric Records | ☐ Medical Records | ☐ Psychological Records |
| ☐ Service Coordination and Treatment Planning | ☐ Employment Records | ☐ Criminal Justice Records | |
| **Please use the this section to write in any additional requests** | | | |
| | | | |

The following agencies are allowed to exchange this information:
Family Assessment and Planning Team members which include representatives from :
• Norfolk Juvenile Court Services • Norfolk Public Schools • Norfolk Public Health • Norfolk Dept. of Human Services • Norfolk Community Services Board • Parent Representatives • Private Provider Representatives

| I agree that information can be shared: | • Written (including facsimile) • By Phone • In Person (including meetings and staffings) • Computerized Data (including e-mail, as appropriate) |
|---|---|

This consent is valid until ______________________________________________
(If left blank, consent expires one (1) year after signature date)

Signature of Consenting Person: ______________________________________________
(Signature) (Date)

Signature of Person Explaining Form: ______________________________________________
(Printed Name) (Signature) (Date)

Witness (If required): ______________________________________________
(Printed Name) (Signature) (Date)

______________________________________________
(Witness' Address and Telephone Number)

I can withdraw this consent at any time by completing the section below and submitting this form to the referring agency. This will stop the listed agencies from sharing information after my consent has been withdrawn. I have the right to know what information about me was shared; when it was shared; to whom it was shared; and the reason it was shared. If I ask, each agency will show me this information. I instruct all agencies to accept a copy of this form as a valid consent to share information. If I do not sign this form, my information will not be shared. I will have to contact each agency individually to give them necessary information.

Consent withdrawal: ______________________________________________
(Date of withdrawal) (Printed Name) (Signature)