Rev.10/12/2023

Portsmouth Homeless Action Consortium (PHAC)
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
□ □ Drug / Alcohol Abuse	□ □ HIV	

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:

Housing Crisis Hotline
Portsmouth Coordinated Entry
Portsmouth Resources Area Coalition (PARC)
Portsmouth Volunteers for the-Homeless (PVH)
Help and Emergency Response Shelter (HER)
Eggleston
STOP Inc.
Virginia Supportive Housing
Oasis Social Ministry

Portsmouth Behavioral Healthcare - Services
Portsmouth Department of Health
Portsmouth Public Schools
Portsmouth Department of Social Services
Portsmouth Redevelopment and Housing Authority (PRHA)
Portsmouth Christian Outreach Ministries (PCOM)
Other_____

Legal Aid Society of Eastern Virginia
Maryview Foundation
Life Changers
Disabled American Veterans (DAV)
Department of Veteran Affairs (VA)
Virginia Beach Community- Development Corporation -(VBCDC)
Hampton Roads Community Health

Other _____

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

□ Service Coordination
□ Eligibility Determination
Continued Medical/Mental Health Treatment
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 is in alignment with current HMIS policies and will be effective for a period of one (1) year from the date of execution if verbal and three (3) years if signed.

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 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. (please sign below)

Signature(s) _____ Date _____
(Consenting Person(s))

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

Verbal Consent Confirmation: Date _____ Time_____

Verbal Consent Provided? Circle One: □ Yes □ No

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 #: _____

Client Signature: _____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)