

**GVPHC Services Coordinated And Assessment Network (SCAAN)**

**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 NAME)

\_\_\_\_\_  
(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
<input type="checkbox"/> <input type="checkbox"/> Assessment Information	<input type="checkbox"/> <input type="checkbox"/> Medical Diagnosis	<input type="checkbox"/> <input type="checkbox"/> Educational Records
<input type="checkbox"/> <input type="checkbox"/> Financial Information	<input type="checkbox"/> <input type="checkbox"/> Mental Health Diagnosis	<input type="checkbox"/> <input type="checkbox"/> Psychiatric Records
<input type="checkbox"/> <input type="checkbox"/> Benefits/Services Needed, Planned, and/or Received	<input type="checkbox"/> <input type="checkbox"/> Medical Records	<input type="checkbox"/> <input type="checkbox"/> Criminal Justice Records
	<input type="checkbox"/> <input type="checkbox"/> Psychological Records	<input type="checkbox"/> <input type="checkbox"/> Employment Records

Other Information (write in):

I want:

(NAME AND ADDRESS OF REFERRING AGENCY AND STAFF CONTACT PERSON)

And all GVPHC member agencies to be able to exchange this information. (A full list of member agencies can be found at [www.gvphc.org](http://www.gvphc.org))

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

- Service Coordination and Treatment Planning     Continued Medical/Mental Health Treatment
- Eligibility Determination     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 will be effective for a period of three (3) years from the date of execution.**

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 re-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.***

Signature(s): \_\_\_\_\_ Date: \_\_\_\_\_  
(Client/Consenting Person Signature)

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

**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 #:** \_\_\_\_\_

**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: \_\_\_\_\_

Spouse Signature (If Applicable): \_\_\_\_\_ 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)*