Strengthening Our System, Inc.
177 Gracie Ln, Floyd, VA • 540-585-4078

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.

Recipient's Name: _____

Recipient's Address: _____

Recipient's DOB: _____

Recipient's SSN or 12-digit Medicaid number: _____

My relationship to the recipient is: ☐ Self ☐ Parent ☐ Power of Attorney ☐ Guardian
☐ Other Legally Authorized Representative: _____

I want the following confidential information about the individual (except drug or alcohol abuse diagnosis or treatment information) to be exchanged: (check yes or no for each)

Yes	No		Yes	No		Yes	No	
☐	☐	Assessment Information	☐	☐	Medical Diagnosis	☐	☐	Educational Records
☐	☐	Financial Information	☐	☐	Mental Health Diagnosis	☐	☐	Psychiatric Records
☐	☐	Benefits/Services Needed	☐	☐	Medical Records	☐	☐	Criminal Justice Records
☐	☐	Planned and/or Received	☐	☐	Psychological Records	☐	☐	Employment Records
☐	☐	Other Information (write in):						

between: Strengthening Our System, Inc., the referring agency, SOS, Inc.
177 Gracie Ln, Floyd VA 24091 540-585-4078 Fax: 540-745-6710
James Armentrout, LPC, Director of Mental Health Services and:

Agency Name:_____

Address: _____

Phone/Fax:_____

No other agencies are included in this form.

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 This will stop the listed agencies from sharing information after they know my consent has been withdrawn.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** ____ _____

Person Explaining Form/Title: _____**Date** _____

Address: SOS, Inc. 177 Gracie Ln, Floyd VA 24091 **Phone number** 540-585-4078 office

Witness (if required) _____ _____
Signature **Address** **Phone #:**