NAMI NORTHERN VIRGINIA CONSENT TO RELEASE/EXCHANGE INFORMATION

I understand that my family will be participating in a support and planning process that may involve multiple agencies and providers under the provisions of Family Support Partner Services. The purpose of Family Support Partner Services is to provide high quality, cost effective, community-based peer support services to youth with specialized needs and their families. Each agency and provider offers different services and benefits. Each agency must have specific information in order to be of assistance. By signing this form, I am allowing agencies and providers to exchange certain information about my child and family so it will be easier for them to work together effectively to provide or coordinate services or benefits. All information about children and families obtained by team members to perform their responsibilities shall be confidential.

I, _____ am signing this form for _____ _____
(Full Printed Name of Consenting Person or Persons) (Full Printed Name of Client) (Birthdate if under 22)

Relationship to youth: ☐ Self ☐Parent ☐Power of Attorney ☐Guardian/Custodian ☐Other Legally Authorized Representative

_____
(Client's Street Address) (City) (State) (Zip Code)

I want the following confidential information about the client to be exchanged with the agencies and parties listed below:

CHECK NO ONLY IF YOU DO NOT WISH TO SHARE THIS INFORMATION:

Assessment Information	☐NO	Medical Diagnosis	☐NO	Educational Records	☐NO
Benefits/Services Needed, Planned and/or Received	☐NO	Medical Records	☐NO	Psychiatric Record	☐NO
NAMI Northern Virginia Care Plan/ Discharge Summary	☐NO	Mental Health Diagnosis	☐NO	Juvenile Justice Records	☐NO
		Behavioral Health Care Records	☐NO	Employment Records	☐NO

Other Information (write in): _____

I want: _____
(NAME AND ADDRESS OF REFERRING AGENCY AND STAFF CONTACT PERSON)

and the following other agencies and their representatives to be able to exchange information for service planning, coordination and eligibility determination: NAMI Northern Virginia, Team-based Planning teams, Family Assessment and Planning Team (FAPT), Community Policy and Management Team (CPMT) members and member agencies to include the Health Department; Department of Family Services; Juvenile and Domestic Relations District Court; Public Schools; Community Services Board; TBP/FAPT/CPMT parent representatives; TBP/FAPT/CPMT private agency representatives; and any other prospective/actual vendor/agency providing services outlined on the services plan developed by these teams and myself.

Other service providers or agencies: (example: hospital, private provider)

_____
(NAME AND ADDRESS OF HOSPITAL, AGENCY OR PROVIDER AND STAFF CONTACT PERSON)

_____
(NAME AND ADDRESS OF HOSPITAL, AGENCY OR PROVIDER AND STAFF CONTACT PERSON)

I understand that:

- Information will be exchanged by written, verbal and computerized methods.
- I can withdraw this consent any time by notifying 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.

I want to share additional information received after this consent is signed.

NAMI Northern Virginia may wish to send you information or communicate with you electronically. Please provide us with your email address if you agree to receive electronic communication.

EMAIL: _____

SIGNATURE(s) of consenting person(s): _____ _____*Date:* _____

EXPIRATION DATE: (*please indicate a precise date and do not exceed 2 years from the date signed*): _____

Person Explaining Form: _____

Witness (If Required): _____

*Age recommendations for client signature (in addition to Guardian signature): 14 and older

A copy of the signed consent must be given to the person(s) or family providing consent, and a copy placed in the client's case record. The information released pursuant to this authorization may be subject to re-disclosure by the recipient and may be no long be protected by federal privacy law.

TO THE RECIPIENT OF RECORDS RELATED TO THE TREATMENT OF ALCOHOL AND/OR DRUG ABUSE: This information is being disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulation (42 CFR Part 2) prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.