



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 which will allow them to work together effectively to provide or coordinate these services and benefits.

I, _____, am signing this form for
(Full printed name of consenting person or persons)

(Full printed name of Individual/client)

(Medicaid #)

(Individual' address)

(Birth date)

I want the following confidential information about this person to be exchanged: (check)

- Assessment information
- Financial information
- Benefits/services needed, Planned, and/or received
- Medical Records
- Other information requested _____
- Mental Health Diagnosis
- Psychological Records
- Educational Records
- Psychiatric Records

I request **PAN Homehealth Support Services and its Employee (s)**
(Name and Address of referring agency and staff/contact)

and the following agencies to be able to exchange information.

Fairfax CSB

Dentist

Primary Physician

Other(s) _____

Psychiatry

This information is exchanged ONLY for the following purpose(s):

- Service Coordination & Treatment
- Eligibility Determination
- Other _____

I want the following information to be shared: (check all that apply)

- Written information
- Meetings and/or phone
- Computerized data
- Additional information received following this consent

This consent is applicable for one year after the signature date and may be revoked at any time. All information released will be strictly confidential. No other information will be released except as required by law.



Signature(s) _____ Date: _____
(Consenting Person or Persons)

Person assisting w/form _____
(Name) (Title) (Phone #)