Arlington County Interagency Family Assessment and Planning Team

CONSENT OF 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 for
(FULL PRINTED NAME OF CONSENTING PERSON OR PERSONS)

_____
(FULL PRINTED NAME OF CLIENT)

_____
(CLIENT'S ADDRESS) *(CLIENT'S BIRTH DATE)* *(CLIENT'S SSN)*

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

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

I want the following confidential information about the client. I understand that the information will be shared in written form, in meetings, by phone or by computerized data.

Yes	No		Yes	No		Yes	No	
☐	☐	Assessment Information	☐	☐	Medical and Behavioral Health Diagnosis & Records	☐	☐	Educational Records
☐	☐	Financial Information				☐	☐	Criminal Justice Records
☐	☐	Benefits/Services Needed, Planned, and/or Received	☐	☐	Substance Abuse Diagnosis & Treatment	☐	☐	Employment Records

I understand that the Arlington County Family Assessment and Planning Team (FAPT) and Community Policy and Management Team (CPMT) is composed of representatives from the following agencies:

Arlington County Department of Human Services
Arlington Public Schools
Parent Representative
Arlington County Juvenile and Domestic Relations Courts
Private Agencies

These agencies will be sharing information about my son or daughter for service coordination and treatment planning. Failure to give consent for exchange of information between all listed agencies stops this interagency referral process for possible services for my child.

This consent is effective from:_____to _____**(no more than 12mos)**

PLEASE SEE BACK OF THIS PAGE – CONSENTING PERSON MUST SIGN

- I can withdraw this consent at any time by notifying the informing agency in writing. This will stop the listed agencies from sharing information after they know my consent has been withdrawn.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 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 the information that they need.

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

Signature(s) _____ Date _____
(Youth signature if substance abuse diagnosis and treatment information to be shared)

Person Explaining Form: _____
Name Title Phone Number

Witness (If Required): _____
Signature Address Phone Number

NOTE WHERE INFORMATION ACCOMPANIES THIS DISCLOSURE FORM: This information has been disclosed to you from records protected by Federal Confidentiality of alcohol or Drug Abuse Patient Records rules (42CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

FOR AGENCY USE ONLY

CONSENT HAS BEEN:

☐ Revoked in entirety
☐ Partially revoked as follows:

NOTIFIFAPTION THAT CONSENT WAS REVOKED WAS BY:

☐ Letter (Attach Copy) DATE REQUEST RECEIVED:_____

AGENCY REPRESENTATIVE RECEIVING REQUEST:

_____
(AGENCY REPRESENTATIVE'S FULL NAME AND TITLE)

_____
(AGENCY ADDRESS)