



Children's Services Act (CSA)

Consent to Release and Exchange of Confidential 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 DATE OF BIRTH)

(LEGAL ADDRESS OF THE CLIENT)

My relationship to the client is: Self Parent Legal Guardian Other Legally Authorized Representative

I authorize the following confidential information about the client 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"/> Substance Abuse Records | <input type="checkbox"/> <input type="checkbox"/> Psychological Records | <input type="checkbox"/> <input type="checkbox"/> Employment Record |
| | <input type="checkbox"/> <input type="checkbox"/> Other information: _____ | |

with:

(NAME OF REFERRING AGENCY AND STAFF CONTACT PERSON)

And other professional representatives from, but not restricted to:

York County/City of Poquoson Family Assessment and Planning Team and York County/City of Poquoson Community Policy and Management Team (to include York-Poquoson Social Services, 9th District Court Services Unit, Colonial Behavioral Health, York County School Division, Poquoson City Public Schools, the Peninsula Health Department, and other community professionals/representatives)

Are more agencies listed on the back? YES NO

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

- Service Coordination and Treatment Planning Eligibility Determination
 Other: _____

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 (max of 1 year from signature date): _____

I can withdraw this consent at any time. My revocation is not effective until delivered in writing to the person who is in possession of my records. 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:** _____
(Consenting Person Or Persons)

Person Explaining Form: _____
(Name) (Title) (Phone Number)

Witness (If Required): _____
(Signature) (Address) (Phone Number)