# 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.

I, _____ am signing this form for
(FULL PRINTED NAME OF CONSENTING PERSON OR PERSONS)

_____
(FULL PRINTED NAME OF CONSUMER)

_____
(CONSUMER'S ADDRESS) (CITY, STATE, ZIP)

_____
(CONSUMER'S BIRTHDATE) (CONSUMER'S SSN—OPTIONAL)

My relationship to the Consumer is:

☐Self ☐Parent ☐Power of Attorney

☐Guardian ☐Other Legally Authorized Representative

I want the following confidential information about the Consumer (**except drug or alcohol abuse diagnoses or treatment information**) to be exchanged:

☐Assessment Information ☐Medical Diagnosis ☐Educational Records

☐Financial Information ☐Mental Health Diagnosis ☐Psychiatric Records

☐Medical Records ☐Criminal Justice Records ☐Psychological Records

☐Employment Records ☐Benefits/Services Needed, Planned, and/or Received

☐Other Information (write in):_____

**I want the staff of Brain Injury Solutions, 3904 Franklin Road, Suite B, Roanoke, VA 24014-3039**,

**AND**

**Name and address of referring agency and the following other agencies to be able to exchange this information:**

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 This will stop the listed agencies from sharing information after they know my consent has been withdrawn.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: _____ Expires: _____
(CONSENTING PERSON OR PERSONS) (1 year from date of signature)

Person Explaining Form: _____

Title: _____ Phone: _____

Note: This Information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR 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.

**Brain Injury Solutions is not a Healthcare Provider.**