CONSENT TO EXCHANGE INFORMATION
ESC Lake Erie West – ALC West

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 BIRTHDATE) (CLIENTS SSN – OPTIONAL)

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

I want the following confidential information (except drug or alcohol abuse diagnosis or treatment information) about the client to be exchanged:

Yes	No		Yes	No		Yes	No	
☒	☐	Assessment Information	☒	☐	Medical Diagnosis	☒	☐	Educational Records
☐	☒	Financial Information	☒	☐	Mental Health Diagnosis	☒	☐	Psychiatric Records
☐	☒	Benefits/Services Needed Planned, and/or Received	☒	☐	Psychological Records	☐	☒	Employment Records
			☒	☐	Current Medications	☒	☐	Criminal Justice Records

Other Information (write in):

I want: ***The Educational Service Center of Lake Erie West/Alternate Learning Center***
3939 Wrenwood Drive; Toledo, Ohio 43623 FAX (419) 473-3445
(NAME AND ADDRES OF REFERRING AGENCY AND STAFF CONTACT PERSON)

And the following agency to be able to exchange this information:

_____
(Agency Name) (Agency Address) (Agency Phone Number)

I want this information to be exchanged ONLY for the following purpose(s):
☒ Service Coordination and Treatment Planning ☐ Eligibility Determination
Other (write in): _____

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

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 This will stop the listed agencies from sharing information after they know my consent has been withdrawn.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: _____

(CONSENTING PERSON OR PERSONS)

Person Explaining Form: _____

(Name) (Title) (Phone Number)

Witness (If Required): _____

(Signature) (Address) (Phone Number)

5-14-92
032-01-005

This consent expires one year from today's date.

UNIFORM CONSENT TO EXCHANGE INFORMATION FORM

FULL PRINTED NAME OF CLIENT: _____

FOR AGENCY USE ONLY

CONSENT HAS BEEN:

☐ Revoked in entirety
☐ Partially revoked as follows:

NOTIFICATION THAT CONSENT WAS REVOKED WAS BY:

☐ Letter (Attach Copy) ☐ Telephone ☐ In Person

DATE REQUEST RECEIVED: _____

AGENCY REPRESENTATIVE RECEIVING REQUEST:

_____

(AGENCY REPRESENTATIVE'S FULL NAME AND TITLE)

_____

(AGENCY ADDRESS AND TELEPHONE NUMBER)

Rev. 5/4/2015