VETERANS CONSENT TO EXCHANGE INFORMATION

CLIENT: **DATE OF BIRTH:** **VULNERABILITY SCORE:**	**The client must always be given a copy of this form after signing.** Complete as needed. Use for exchanging information between agencies listed on this form.

The Orange County Partnership to End Homelessness has formed an interagency workgroup, called the Orange County Homeless Veterans Working Group, to work toward connecting homeless people in our community to appropriate services, stable housing, and needed community resources. This concerted effort includes several local groups and individuals including the Department of Veterans Affairs; Orange County Department of Social Services, Volunteers of America, EmPOWERment, NC Housing Finance Agency, and the Interfaith Council for Social Service (IFC). The purpose of this form is to provide your consent for the members of the Homeless Veterans Working Group to exchange information about you to coordinate their services to better help you.

I**,** [print name]_____**,** hereby authorize the exchange of information to/from:

- Orange County Partnership to End Homelessness/Orange County Homeless Veterans Working Group
- _____
- _____
- _____

Please **initial** below indicating which information regarding your treatment may be exchanged. Release of information is limited to the minimum necessary to accomplish the purpose for which the request is made.

_____ I authorize periodic exchange of information between the above noted agencies, including information related to assessment/diagnoses, medical history, and treatment history.
_____ I authorize the exchange of information even if such exchange contains information related to mental health treatment.
_____ I authorize the exchange of information even if such exchange contains information related to substance abuse.
_____ I authorize the exchange of information even if such exchange contains information related to HIV/AIDS or sexually transmitted diseases.
_____ I authorize the exchange of information even if such exchange contains information related to genetic testing.
_____ Other (specify) _____

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CLIENT:

DATE OF BIRTH:

I understand what information will be released, the purpose for the release of the information, and that there are statutes and regulations protecting the confidentiality of the information to be released. I understand further that the federal privacy law (45 CFR Part 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure.

I understand the terms of this release and voluntarily give my authorization. I understand that I may refuse to sign this authorization form and understand that my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned on any of the entities listed above receiving my signature on this authorization.

I further understand that I may revoke my authorization by giving written notice to any member of this working group. Such revocation does not affect the validity of the consent for information disclosed prior to the revocation. If not revoked earlier, this authorization expires automatically one year from the date it is signed or upon _____, whichever is earlier. *(date or event specified by client or dictated by the purpose of the authorization)*

I have read and understand the information in this Consent to Exchange Information form.

Signed _____ Date _____
(Specify if signature is that of client, parent(s), legal guardian, or personal representative)

If not signed by client, explain representative's authority to act on behalf on client:

_____

Witnessed _____ Date _____
*(Witness signature is required only if the form is sent out of state **or** if the above client signature has been signed by a mark)*

This authorization is hereby revoked upon the signed and dated request of the client as noted below:

Signed _____ Date _____
(Client signature)

The client has notified me verbally that s/he wishes to revoke this authorization with an effective date of

_____ *(Effective date)***.**

Signed _____ Date _____
(Staff signature)

THE INFORMATION RELEASED IS CONFIDENTIAL AND REDISCLOSURE IS PROHIBITED EXCEPT AS SPECIFICALLY AUTHORIZED BY STATE OR FEDERAL LAW.