COMMONWEALTH OF VIRGINIA
UNIFORM AUTHORIZATION TO USE AND EXCHANGE INFORMATION

I understand that different agencies provide different services and benefits. Each agency must have specific information to provide services and benefits. By signing this form, I allow agencies to use and exchange certain information about me, including information in an electronic database, so it will be easier for them to work together efficiently to provide or coordinate these services or benefits.

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

____
(FULL PRINTED NAME OF INDIVIDUAL)

____
(INDIVIDUAL'S ADDRESS) *(INDIVIDUAL'S BIRTH DATE)* *(INDIVIDUAL'S SSN – OPTIONAL)*

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

I want the following confidential information about the individual 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	☐	☐	Medical Records	☐	☐	Criminal Justice Records
			☐	☐	Psychological Records	☐	☐	Employment Records
☐	☐	Substance Abuse Records				☐	☐	All of the Above

Other Information (write in): ______________________________

I want ____

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

and the following entities to be able to use and exchange this information among themselves:

Yes	No		Identify By Name	
☐	☐	No Wrong Door Tools/SeniorNavigator	____________	Area Agencies on Aging
☐	☐	Dept. of Medical Assistance Services	____________	Centers for Independent Living
☐	☐	DMHMRSAS	____________	Community Services Boards
☐	☐	DRS Local/Regional	____________	Dept. of Social Services
☐	☐	Dept. Blind and Visually Impaired	____________	Home Health Agencies
☐	☐	Dept. Deaf and Hard of Hearing	____________	Hospices
			____________	Hospitals
		Other: ____________	____________	Local Health Departments
			____________	Nursing Facilities
			____________	Physicians

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

I want this information to be shared by the following means: *(check all that apply)*
☐ Written Information ☐ In Meetings or By Phone ☐ Computerized Data ☐ Fax

I want to share additional information received after this authorization is signed: ☐ Yes ☐ No

This authorization is effective: ____________
(DATE)

This authorization is good until: ☐ My service case is closed. ☐ Other: ____________
For No Wrong Door this authorization is valid for one year from date of signature, unless the individual or his authorized representative specify an expiration date, event or condition that will occur prior to one year from the date of signature.

I can withdraw this authorization at any time by telling the referring agency. The listed agencies must stop sharing information after they know my authorization 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 agencies to accept a copy of this form as valid authorization 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 information about me that is needed.** However, I understand that treatment and services cannot be conditioned upon whether I sign this authorization. There is a potential for information disclosed pursuant to this authorization to be re-disclosed by the recipient and not be subject to the HIPAA Privacy Rule.

Signature(s): ______________________________ Date: ____________
(AUTHORIZING PERSON OR PERSONS)

Person Explaining Form: ______________________________
(Name) *(Address)* *(Phone Number)*

Witness *(If Required)*: ______________________________
(Signature) *(Address)* *(Phone Number)*

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Full Printed Name of Individual: ____

<u>FOR AGENCY USE ONLY</u>

AUTHORIZATION HAS BEEN:

☐ Revoked in entirety
☐ Partially revoked as follows:

NOTIFICATION THAT AUTHORIZATION WAS REVOKED WAS BY:

☐ Letter (Attach Copy) ☐ Telephone ☐ In Person

DATE REQUEST RECEIVED: _______________

AGENCY REPRESENTATIVE RECEIVING REQUEST:

____

(AGENCY REPRESENTATIVES FULL NAME AND TITLE)

____

(AGENCY ADDRESS) *(PHONE NUMBER)*