

**CITY OF ALEXANDRIA**  
**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	
<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 Records
						<input type="checkbox"/>	<input type="checkbox"/>	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
<input type="checkbox"/>	<input type="checkbox"/>	Alexandria City Public Schools	_____
<input type="checkbox"/>	<input type="checkbox"/>	Alexandria Community Services Board	_____
<input type="checkbox"/>	<input type="checkbox"/>	Alexandria Court Service Unit	_____
<input type="checkbox"/>	<input type="checkbox"/>	Alexandria Department of Human Services	_____
<input type="checkbox"/>	<input type="checkbox"/>	Alexandria Health Department	_____
<input type="checkbox"/>	<input type="checkbox"/>	Alexandria Police Department	_____
<input type="checkbox"/>	<input type="checkbox"/>	Family Assessment & Planning Team	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hospices	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hospitals	_____
<input type="checkbox"/>	<input type="checkbox"/>	Local Health Departments	_____
<input type="checkbox"/>	<input type="checkbox"/>	Nursing Facilities	_____
<input type="checkbox"/>	<input type="checkbox"/>	Physicians	_____

Other \_\_\_\_\_

**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)