

RS-3i (12/95) **Commonwealth of Virginia Department of Rehabilitative Services**
Uniform Consent to Exchange Information 3/06 CBS DIV

Return the requested information to:

Patricia Goodall, Ed.S.
 Director, Brain Injury & Spinal Cord Injury Services
 8004 Franklin Farms Drive
 Richmond, VA 23229
 Phone: (804) 662-7615 or (800) 552-5019
 Fax: (804) 662-7663; E-mail:
patti.goodall@drs.virginia.gov

Important Information: I understand that different agencies provide different services and benefits. Each agency has specific information needs. By signing this form, I am allowing the agencies listed to work more effectively to provide or coordinate services or benefits. I understand that if I have reached the age of 18 and am not under a legal guardianship conferred by the court, that my parents cannot have access to my case file or to any confidential information related to me and cannot discuss my case with DRS or make decisions regarding my case without my express, written consent. **I also understand that the release of information provided by other agencies is subject to that agency's terms of release.**

(1) I, (*consenting person's name*) _____, am signing this form for
 (*full name of consumer*) _____ of
 (*consumer address*) _____

(2) (*consumer birthdate*) _____ (3) Consumer *SSN (optional)* _____

(4) Relationship to consumer (*check one*): Self Parent Power of attorney Legal Guardian

(5) I want the following information about the consumer to be exchanged. **Drug and alcohol treatment information cannot be released through signature on this form. The release of such information requires use of the Interagency Consent to Release Information for Alcohol or Drug Patients.** A "yes" or "no" response **must** be indicated for each category.

- | | | | | | | | | |
|---|---|-----------------------------|----------------------------|---|-----------------------------|------------------------------|---|-----------------------------|
| 1. Assessment Info | Yes <input checked="" type="checkbox"/> | No <input type="checkbox"/> | 4. Medical Diagnosis | Yes <input checked="" type="checkbox"/> | No <input type="checkbox"/> | 8. Educational Records | Yes <input checked="" type="checkbox"/> | No <input type="checkbox"/> |
| 2. Financial Info | Yes <input checked="" type="checkbox"/> | No <input type="checkbox"/> | 5. Mental Health Diagnosis | Yes <input checked="" type="checkbox"/> | No <input type="checkbox"/> | 9. Psychiatric Records | Yes <input checked="" type="checkbox"/> | No <input type="checkbox"/> |
| 3. Benefits/Services Needed
Planned, or Rec'd. | Yes <input checked="" type="checkbox"/> | No <input type="checkbox"/> | 6. Medical Records | Yes <input checked="" type="checkbox"/> | No <input type="checkbox"/> | 10. Criminal Justice Records | Yes <input checked="" type="checkbox"/> | No <input type="checkbox"/> |
| | | | 7. Psychological Records | Yes <input checked="" type="checkbox"/> | No <input type="checkbox"/> | 11. Employment Records: | Yes <input checked="" type="checkbox"/> | No <input type="checkbox"/> |

Other Information (*write in*) _____

(6) I want the Virginia Department of Rehabilitative Services through Patricia Goodall, Director of Brain Injury & Spinal Cord Injury Services and the following other agencies and/or individuals to be able to exchange/provide the following information (*attach extra sheets if necessary*):

Name of Agency/Individual	Address/Phone	Type of Info
Patricia Goodall, DRS Brain Injury & Spinal Cord Injury Services and Brain Injury Direct Services (BIDS) Fund; and Carolyn Turner, DRS Community Rehabilitation Case Management (CRCM) Services	8004 Franklin Farms Drive Richmond, VA 23229 804/662-7615; 800/552-5019	#1 above through #11
Family Members (list all with whom information can be shared):		#1 above through #11

(7) I want information to be shared through the following means or mechanisms (*check all that apply*):
 Written Information In Meetings or by Phone Computerized Data

Commonwealth of Virginia Department of Rehabilitative Services Uniform Consent to Exchange Information

(8) I want this information to be exchanged only for the following purpose(s) (*check all that apply*):

Service Coordination and Treatment Planning

Eligibility Determination

Job Placement (*release of information to employers*)

Coordination with Vendors/Providers

Other (*write in*) _____ as needed by the DRS Brain Injury Direct Services (BIDS) Fund to solicit and coordinate specialized treatment and rehabilitation services.

(9) I want to share additional information received and/or included in my records after this consent is signed (*check one*): Yes No

(10) I want to place the following restrictions on information to be shared (*specify*):

(11) This consent is good until (*date no later than one year from the date of signature*) _____

I can withdraw this consent at any time by notifying my DRS counselor. My DRS counselor will notify the listed agencies that my consent has been withdrawn which will stop the agencies from sharing information. I have the right to know what information about me has been shared and why, when, and with whom it was shared. Unless prohibited by law or regulation, each agency will show me this information if I ask to see it. I would like all of the listed agencies/individuals 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 the information they need or complete a separate consent form for each information request.**

(12) Consenting person's signature _____	Date _____
(13) Person explaining form, title _____	Phone _____
(14) Witness signature (if required) _____	Phone _____
Witness Address _____	

For DRS Use Only

Consent has been: Revoked in entirety Partially revoked as follows (*specify below*)

Revoked on (*date*) _____ By (*check one*): Letter (*attach copy*) Phone In Person

Received by _____ Title _____ Phone _____

Office address _____ Fax _____

Directions for Filling out and Returning the Release of Information Form

The **Virginia Department of Rehabilitative Services (DRS)** may provide services to you through the Brain Injury Direct Services (BIDS) Fund, part of the DRS Community Based Services Division. We need your written permission to share information among family members and service providers to help plan for and provide services. Please review the enclosed *Uniform Consent to Exchange Information* (release of information) form carefully and do the following:

- ☒ If you **agree with all** of the information on the form - *including the boxes that are already checked* - simply fill out the highlighted areas. Sign/date the form on page 2.

OR

- ☒ If you **want to change any** of the information on the form - *including any of the boxes that area already checked* - make any changes that you wish and put your initials beside it. Then, sign and date the form on page 2.

Return the form to:

DRS Brain Injury Services, 8004 Franklin Farms Drive,
Richmond, VA 23229, **ATTN:** Patricia Goodall

Questions?

Call Patti Goodall at (804) 662-7615 or (800) 552-5019

or

E-mail Patti.Goodall@drs.virginia.gov

Thank you!