

INTER-AGENCY AUTHORIZATION TO EXCHANGE INFORMATION

_____ Consumer Name _____ Date of Birth _____ Consumer ID Number/Booking Number _____

I, _____ (Consumer/Parent/Legal Guardian) hereby authorize the following persons and agencies identified below to exchange verbal and/or written information about me/the child/the individual, as indicated by my initials and written instructions below. In doing so, I am aware that I may, without penalty, refuse consent for the exchange of information by any of the persons or agencies listed. (Legal Guardian or Court Wards may be subject to legal sanctions if they refused to sign). I understand the purpose of the Inter-Agency Exchange is to develop a constructive, workable plan that is in my/the child's/the individual's best interest.

AGENCY	YES <i>(Initial)</i>	INFORMATION TO BE EXCHANGED*
60th District Court Probation	_____	_____
Arbor Circle	_____	_____
Bethany Housing, Ministries dba, Community enCompass	_____	_____
Big Brothers Big Sisters of the Lakeshore	_____	_____
Calvary Christian Schools	_____	_____
Case Managers Committee	_____	_____
Catholic Charities of West Michigan	_____	_____
Child Abuse Council of Muskegon	_____	_____
CHIR Collaborative Referral Specialist	_____	_____
Community enCompass	_____	_____
Dept. Of Health & Human Services	_____	_____
Disability Network West Michigan	_____	_____
Divine Providence Academy	_____	_____
Every Woman's Place	_____	_____
Family Promise	_____	_____
Fruitport Community Schools	_____	_____
Goodwill Industries of West Michigan	_____	_____
Great Lakes Health Connect	_____	_____
Hackley Community Care	_____	_____
HealthWest	_____	_____
Holton Public Schools	_____	_____
Judge _____	_____	_____
Love INC of Muskegon County	_____	_____
Mediation & Restorative Services	_____	_____
Mercy Life Counseling	_____	_____
Michigan Health Information Network	_____	_____
Michigan Rehabilitation Services	_____	_____
Mona Shores Public Schools	_____	_____
Montague Area Public Schools	_____	_____
Muskegon Area ISD	_____	_____
Muskegon Catholic Central	_____	_____
Muskegon Community Health Project	_____	_____

- SPECIFIC INFORMATION TO BE EXCHANGED***
1. Jail Assessments
 2. Intake
 3. Assessments/Evaluation
 4. Plan of Service/Agreements
 5. Medical Reports
 6. Psychiatric Reports
 7. Progress Reports
 8. Alcohol/Other Drug Reports
 9. Educational/Vocational
 10. Court/Legal Report
 11. Residential Reports
 12. Compass
 13. Contact Information
 14. Other _____

***Note:** Alcohol and/or drug treatment information, personal health information, and information about serious communicable disease (HIV,ARC, AIDS, STD, TB) are subject to Federal and State of Michigan confidentiality regulations (see below). See instruction "F" on back. Any person or agency receiving information may not release that information to another agency/ person. Information must be requested from the agency of origin.

AGENCY CONT'D

YES *(Initial)*

INFORMATION TO BE EXCHANGED*

Muskegon County Com. Corrections		
Muskegon County Family Court		
Muskegon County Juvenile Transition Ctr		
Muskegon County Prosecutor		
Muskegon County Sheriff's Office		
Muskegon Covenant Academy		
Muskegon Family Care		
Muskegon Heights Public PSA		
Muskegon-Oceana Community Action Partnership		
Muskegon Pregnancy Center		
Muskegon Rescue Mission		
North Muskegon Public Schools		
Oakridge Public Schools		
Orchard View Schools		
Pathfinders		
Planned Parenthood - Muskegon Health Center		
Public Health of Muskegon County		
Ravenna Public Schools		
Read Muskegon		
Reeths-Puffer Schools		
Social Security Administration		
State of Michigan Parole		
State of Michigan Probation		
Step Up		
The Hope Project		
The Salvation Army		
Three Oaks Public School Academy		
Timberland Charter Academy		
Western Michigan Christian High School		
West Michigan Works		
West Shore Lutheran School		
Whitehall District Schools		
YMCA		
Other _____		

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PURPOSE FOR SUCH DISCLOSURE		
<input type="checkbox"/> Coordination of Services	<input type="checkbox"/> School Planning	<input type="checkbox"/> Treatment Planning
<input type="checkbox"/> Vocational Planning	<input type="checkbox"/> Legal/Court Proceedings	<input type="checkbox"/> Other
<p>This consent is subject to a written revocation at any time except in those circumstances in which the Program has taken certain actions in reliance on such consent. However, this consent shall be valid no longer than is reasonably necessary to accomplish the purpose of the actions for which it was given. My authorization is voluntary and will automatically expire once the purpose for which it was signed is accomplished, or this consent will automatically expire on _____ (one year) unless revocation is made prior to this date.</p>		

I further understand that information exchanged as a result of this authorization will be exchanged only with those persons in an agency with a legitimate interest in such information. My signature verifies my authorization for information exchange and that I have read this form and/or have had it read to me and explained in language that I can understand.

Signature of Consumer	Date Signed	Witness	Date
Signature of Parent/Legal Guardian	Date Signed	Witness	Date
Signature of Child (if appropriate)	Date Signed	Witness	Date

PROCEDURES FOR COMPLETION

- A. All consents to exchange consumer information must be documented on the "Muskegon County Inter-Agency Authorization to Exchange Information" form and minimally must include:
 - 1. Name of the consumer, date of birth, and booking number/consumer ID number;
 - 2. Name of exchanging person(s), agency(ies), and organization(s);
 - 3. Type of information to be exchanged;
 - 4. Purpose of the exchange;
 - 5. Signature of authorizing individual;
 - 6. Signature of a witness;
 - 7. Date signed;
 - 8. Referring Agent: (Agency or full name of person)
- B. The consumer, parent, or legal guardian will place their initials in the "Yes" column next to each person, agency or organization with whom they wish information to be exchanged.
- C. The consumer, parent, or legal guardian will write the number(s) of the "Specific Information to be Exchanged" in the column labeled "Information to be Exchanged."
- D. The originating person(s), agency(ies), or organization(s) will review the Authorization to Exchange Information form with the consumer so as to ensure informed consent regarding what information may be exchanged amongst the designated person, agencies or organizations.
- E. The Authorization to Exchange Information form is not signed until all required categories are completed. No corrections, modifications or additions to an authorization may be made once signatures are obtained. If corrections, modifications or additions are needed, a new authorization form must be completed.
- F. Minors (person under 18) **must** sign their Authorization to Exchange Information when alcohol/other drug abuse or serious communicable disease information is being exchanged. A minor child over age 12 may authorize the exchange of information to enable receipt of initial alcohol and/or drug treatment counseling without parent or guardian consent.
- G. An Authorization to Exchange Information for a consumer who has a legal guardian must be signed by the legal guardian. An Authorization to Exchange Information for a child must be signed by the child's parent with **legal custody** or by the child's legal guardian. Note: "F" above applies.
- H. A copy of the completed Authorization to Exchange Information form will be sent to the identified person(s), agency(ies), or organization(s) named on the form. The original form will be maintained in the consumer record of the originating agency.
- I. An Authorization to Exchange Information may be revoked at any time. If a consumer wishes to revoke an authorization, any of the consumer's agency staff identified on the form must document on the authorization form in red ink the word "REVOKED", the date, and his/her initials. The events contributing to the revocation must be documented in the consumer's record. A copy of the revoked authorization form is forwarded to the other named person(s), agency(ies), or organization(s) on the form.

Notice: A person's alcohol and/or drug treatment records are protected under federal regulations governing Confidentiality of Alcohol and Drug Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 & 164, and cannot be disclosed without proper written consent unless otherwise provided for in the regulations. HIV-related, STD-related, and TB-related information about a person is protected by HIPAA, and by state law and cannot be disclosed without their consent unless the disclosure is otherwise authorized by state or federal law.