



FAMILY SUPPORT TEAM

AGREEMENT FOR EXCHANGE OF INFORMATION

Client Name: _____ Date of Birth: _____

I allow communication between the members of my Family Support Team listed below for the purpose of service coordination. Any communication about protected health information will only be discussed if additional releases giving that permission are signed.

I understand that communication may consist of: (initial bellow)

- Discussion of my current service plan with each agency.
- Determination of priotiry activitaties that satisfy agency requirements.
- Coordination of resources necessary to achieve the agreed upon activities.
- Development of new or informed service plan activities.

Client initials	Team member name and organization	Team member initials

I understand that my agreement to allow this exchange of information can be revoked in writing at any time.

Signature: _____ Date: _____