

**FAMILY SUPPORT TEAM**

**AGREEMENT FOR EXCHANGE OF INFORMATION**

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| --- | --- | --- | --- |
| Client Name: | Click here to enter text. | Date of Birth: | Click here to enter a date. |

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 priority activitaties that satisfy agency requirements.

Coordination of resources necessary to achieve the agreed upon activities.

Development of new or informed service plan activities.

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| Client initials | Team member name and organization | Team member initials |
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I understand that my agreement to allow this exchange of information can be revoked in writing at any time.

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| Signature: |  | Date: |  |