

Homeless Resource Council of the Sierras' HMIS Client Release of Information

Client Name: _____

Date of Birth: _____

Household Members

Name: _____

Date of Birth: _____

Name: _____

Date of Birth: _____

Name: _____

Date of Birth: _____

Name: _____

Date of Birth: _____

Name: _____

Date of Birth: _____

_____ Is a partner agency in the Homeless Resource Council of the Sierras' Homeless Management Information System (HMIS). The HMIS is used by homeless provider agencies to record information about clients that they serve. This information helps agencies plan for and provide services to clients. With client authorization, this information can be shared among the agencies in order to improve the coordination and delivery of services. The partner agencies listed below utilize the Homeless Resource Council of the Sierras' HMIS, and upon you signing this Release of Information will have access to the information you provide by way of HMIS:

Advocates for Mentally Ill Housing	Project MANA
Connecting Point	Roseville Home Start
City of Roseville	SPIRIT Peer Empowerment Center
Foothills House of Hospitality	St. Vincent de Paul - Roseville
Homeless Resource Council of the Sierras	The Gathering Inn
Nevada County Health and Human Services	The Lazarus Project
Placer County Health and Human Services	The Salvation Army, Grass Valley Corps
Community Beyond Violence	Volunteers of America of Northern California and Northern Nevada
Stand Up Placer	

In addition to the partner agencies listed above, additional partner agencies may later participate in HMIS. By signing this release, I also authorize the partner agencies that participate in HMIS after my signing of this release for the sole purpose of improving the coordination and delivery of services for me. I can obtain a current list of all partner agencies that have access to the HMIS database by contacting _____.

The information that is collected in the HMIS database is protected by limiting access to the database and those agencies and individuals with whom the information may be shared, in compliance with the standards set forth by federal, state, and local regulations governing confidentiality of client records. Every person and agency that is authorized to read and/or enter information into the database has signed an agreement to maintain the security and confidentiality of the information. Any person or agency that is found to violate their agreement may have their access rights terminated and may be subject to further penalties.

BY SIGNING THIS FORM, I AUTHORIZE THE FOLLOWING:

I authorize the partner agencies and their representatives to disclose to and communicate with one another the information regarding my family and me that is collected during the intake process for the sole purpose of participating in HMIS. I understand that this information is for the purpose of assessing our needs and coordinating the delivery of services related to housing, utility assistance, food, counseling and/or other supportive services.

I understand that this Release of Information does not Cover information that is collected outside the HMIS process by partner agencies for services or treatment purposes and that the information about me that is collected during the HMIS process on the Homeless Resource Council of the Sierras' HMIS Forms may consist of the following Personally Identifiable Information (PII) and/or Protected Health Information (PHI), which I authorize to be shared between the partner agencies through HMIS in accordance with this Release of Information:

- Name, Date of Birth, Social Security Number, Race/Ethnicity, Gender, Veteran Status, Physical or Developmental Disability Type and Status, Chronic Medical/Health Conditions, Mental Health Information, HIV/AIDS Information, Substance Abuse Information, Domestic Violence, Household Composition, Income Sources and Amounts, Non-Cash Benefits Sources, Health Insurance Sources, Reason(s) for Homelessness/Housing Crisis, Housing History, Psychiatric and Non-Psychiatric Hospitalizations, Incarcerations, Substance Abuse Treatment, Prior Foster or Group Home Placements, Homeless Status/History (including where and

when homeless services were accessed) Case Manager Information, Emergency Contact Information, Destination, Reason for Leaving.

Release of Information Limitations, if any: _____

I UNDERSTAND THAT:

- This Release of Information will not guarantee that I will receive assistance, and that eligibility for assistance will not be conditioned on whether or not I sign this Release of Information.
- My treatment records are protected under state and federal regulations governing confidentiality of patient records. These records cannot be shared without my written consent except as provided for by state and federal law and regulations.
- To the extent that this Release of Information authorizes disclosure of substance abuse treatment information, and/or medical information, such information is protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2 and the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), 45 C.F.R. Pts. 160 & 164, and unless otherwise provided for in the regulations cannot be disclosed without my written consent, which I hereby give.
- Treatment records, case notes and other confidential information outside the scope of this Release of Information cannot be shared without additional written consent.
- I may revoke this consent at any time except to the extent that information has been shared or action taken in reliance on it prior to the revocation. Any notice to revoke this consent must be made in writing and shall be effective upon receipt.
- I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
- I have been offered a copy of this Release of Information and have the right to receive a copy if requested.
- Any statistical analysis of HMIS data that is released will be aggregate de-identified data and will not reveal any personal identifying information per the De-identification standard outlined in 45 C.F.R. Part 2 164.514(a).
- The partner agencies have signed agreements to treat my information in a professional and confidential manner.
- Staff members of the partner agencies authorized to view my information have signed agreements to maintain the confidentiality of my information.
- Auditors of funders who have legal rights to review the work of this agency, including the U.S. Department of Housing and Urban Development may see your

information. Information made available to these auditors will be limited to information necessary to perform their auditing function.

- Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for release of information for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.
- Bowman Systems, LLC is the software provider. When Bowman Systems works on the system, they may see information about me. Bowman Systems' review of any information about you will be limited to information that is necessary to perform maintenance of their software. Staff members of Bowman Systems have signed agreements to maintain the confidentiality of my information, and I hereby authorize Bowman Systems to view my information to the limited extent necessary to carry out its software provider functions.

By signing this Release of Information, I expressly agree to indemnify, defend and hold harmless the partner agencies and their officers, officials, employees, agents and volunteers, individually and collectively, from any and all liabilities, claims, demands, damages, losses and expenses (including without limitation, defense costs and attorney fees of litigation) arising from this Release of Information, except such loss or damage which was caused by the sole negligence or willful misconduct of a partner agency or its officers, officials, employees, agents and/or volunteers, but only in proportion to the degree of a respective partner agency's sole negligence or willful misconduct.

This consent for Release of Information shall automatically expire on _____, unless revoked earlier.

Client Name (Print) Client Signature Date

If signed by a person other than the client, indicate relationship: _____

Agency Personnel Name (Print) Agency Personnel Signature Date

*File original in the Agency's Client File