HMIS CLIENT ID:

Spokane Regional Continuum of Care

Service Coordination Consent and Release of Information (ROI) Authorization

HMIS Informed Consent and ROI and Service Coordination ROI

HMIS Informed Consent and Release of Information

This Agency participates in the Spokane City/County **Homeless Management Information System (HMIS)**, which is a database that is used to collect information, over time, about the characteristics and service needs of people experiencing homelessness or who are at-risk of homelessness. This information is gathered and stored to improve access to services while also meeting requirements of funders such as the U.S. Department of Housing and Urban Development (HUD).

To provide the most effective services in moving people from homelessness to permanent housing, we need an accurate count of all people experiencing homelessness in Spokane County. To make sure that clients are not counted twice if services are provided by more than one agency, and to facilitate care coordination and housing placement support services, we need to collect some personal information. Your information will be stored in our database for seven (7) years, or when the information is no longer in use. This information may be shared with Partner Agencies for the purpose of providing housing support services. A current list of these Partner Agencies is available at https://my.spokanecity.org/chhs/hmis/partners/. If you have questions about data collection or your rights regarding your personal information, please contact the HMIS System Administrator (hmis@spokanecity.org). *More information about HMIS can be found at https://my.spokanecity.org/chhs/hmis/.*

By signing this form, I give this Agency permission to enter personally identifiable information about me and my listed dependents in HMIS and share information collected about me and my dependents listed on the back of this form with Partner Agencies, for the purpose of care coordination and housing support services, including but not limited to:

- Name, Date of Birth, Sex, Race, Ethnicity, phone number, address
- Program enrollments and assessments
- Housing information
- Use of crisis services, hospitals, and jails
- Case notes and services provided by Partner Agencies
- Basic medical, mental health, substance use, and daily living information
- Employment, income, insurance, and benefit information

By signing this form, I certify I understand that:

- My decision to participate in HMIS will not affect the quality or quantity of services I am eligible to receive from this agency, and will not be used to deny outreach, assistance, shelter, or housing. However, if I do choose to participate, services in the region may improve if we have accurate information about people experiencing homelessness and the services they need.

HMIS CLIENT ID:

- The City of Spokane HMIS guards this information with strict security policies to protect my privacy, using a computer system that is highly secure and uses up-to-date data protection features required for each system user. There may be a risk of a security breach, whereby someone might obtain and use my information. If I ever suspect that my data in HMIS has been misused and/or to report possible injury arising from the use of such data, immediately contact the HMIS System Administrator (hmis@spokanecity.org).
- The purpose of sharing this information with Partner Agencies is to help with care coordination, to improve the services I receive, and allow Partner Agencies to access information about me quickly if needed to coordinated support and services.
- I am entitled to a copy of this release and sharing form.
- I may revoke this permission at any time by delivering or mailing a written statement canceling my consent and release of information to this Agency. Revoking my consent/release will not change anything for people or agencies that had previously received my information.
- I understand that additional Partner Agencies may join the Spokane City/County HMIS and will also have access to this information at that time. I understand that, upon my request, this Agency must provide me with a list of current Partner Agencies before I sign this release of information and must allow me to view the updated list of agencies so long as my release/sharing permission remains in effect. I also understand that my information may be shared with the Washington State Department of Commerce to better understand the characteristics and service needs of people experiencing homelessness or who are at risk of homelessness across the state.
- I understand that my records are protected under Federal and State Confidentiality Regulations (42 CFR, Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR, 160 & 164) and cannot be disclosed without my written consent unless otherwise provided for in the regulations.
- I understand that my HMIS information may be shared with additional agencies to coordinate referral and placement for housing as well as care coordination.
- I understand that my HMIS information may be used to conduct client satisfaction survey's relating to any project offered and controlled by this Release. Client survey's will only be completed by the City of Spokane, CHHS staff.
- This Consent and Release of Information will expire seven (7) years from my last HMIS-recorded activity.

IMPORTANT: Do not enter personally identifying information into HMIS for persons who are:

1) in DV agencies,
2) currently fleeing or in danger from a domestic violence, dating violence, sexual assault, or stalking situation,
3) being serviced in a program that requires disclosure of HIV/AIDS statis (i.e. HOPWA),
4) under the age of 13 with no parent or guardian available to consent to enter the minor's information in HMIS.

If this applies to you, <u>STOP</u> – do not sign this form and let Agency Staff know.

HMIS CLIENT ID:

Dependent Children and Youth (Under 18) in household (if any): First and Last Names

_____ _____

_____ _____

_____ _____

Check ONLY one below:

- ☐ **I DO consent** to the inclusion of personally identifying information about me and my dependents (listed above) and authorize information collected to be shared in the Spokane City/County HMIS and with partner agencies. I understand that my personally identifying information will not be made public and will only be used with strict confidentiality. I understand that I may withdraw my consent at any time.
- ☐ **I DO NOT** consent to the inclusion of personally identifying information about me and my dependents (listed above) for use in the Spokane City/County HMIS and with partner agencies. Non-identifying information will still be collected and shared only as needed and required by funders.

_____ _____

Client Name (Printed) **Staff Name (Printed)**

_____ _____

Client Signature **Staff Signature**

_____ _____

Date **Agency**

HMIS CLIENT ID:

Service Coordination Release of Information (ROI)

I _____ (Client Name) authorize _____ (Agency) to share information regarding my participation in their program(s) for system service coordination. This is designed to help individuals experiencing homelessness get the support they need and progress towards stable housing.

By signing this release, I authorize participating organizations to the exchange of information for the purpose of coordinating services. This may include your name and other identifying information stored in HMIS. Only information that is relevant to coordinating services will be shared. All participating agencies agree to not re-disclose protected information and are required to complete a confidentiality agreement.

The following listed agencies are excluded from this release *(please list all the agencies, if applicable, that you wish to **exclude** from this agreement):*

_____

For the purpose of: 1) providing coordinated housing, 2) to improve coordination of services to support individuals experiencing homelessness to stable housing, and 3) to identify barriers and service gaps that block the path out of homelessness.

Not a condition for service provision: I understand that my authorization is voluntary and that I may refuse to sign this authorization or revoke my authorization at any point. My refusal to sign will not affect my eligibility for benefits or services, payment for or coverage of services, or ability to obtain services.

Right to Revoke: this authorization is subject to revocation at any time except to the extent that the agencies which are to make the disclosures have already acted on those disclosures.

Client Rights: I understand that authorizing use or disclosure of the information above is voluntary. I understand that I do not have to sign this authorization to receive services.

This release does not cover health/mental health/drug treatment information. If needed, an agency specific Release of Information should be used for detailed release of records, including HIPAA releases as appropriate.

By signing below, I acknowledge that I have read and agree to the terms of this document. If the client is 12 years of age or younger, this release must be signed by their parent/guardian. Clients 13 years or age or older must sign this release for it to be valid.

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____