

HMIS CLIENT ID:

Spokane Regional Continuum of Care
Service Coordination Release of Information (ROI)

This Agency participates in the Spokane Regional **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 release does NOT authorize data entry into HMIS. HMIS participation requires a separate HMIS Release of Information. Your household should have already signed an HMIS consent form.*** The information gathered and stored is used to improve access to services while also meeting requirements of funders such as the U.S. Department of Housing and Urban Development (HUD) and the Washington State Department of Commerce.

If you sign the Service Coordination ROI, your information may be shared with Partner Agencies. A current list of these Partner Agencies is available at: <https://my.spokanecity.org/chhs/hmis/partners/>

You may list other entities (such as utility companies, past landlords, etc., that will help us advocate on your behalf). It is up to you to decide who we can speak with. 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/>.*

In addition to the Partner Agencies included in the list, you may list out other agencies or individuals that will help us assist you.

Scan to View List of Partner Agencies



By signing this form, I give this Agency permission to share Personally Identifiable Information (PII) about me and my listed dependents in HMIS and to discuss information collected about me and my dependents. Personally Identifiable Information will not be discussed or shared if I am currently fleeing or in danger from domestic violence, dating violence, sexual assault, or stalking. Only non-identifying information may be used in these cases.

For the Purpose of: 1) providing coordinated housing services, 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.

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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.

I _____ (Client Name) authorize _____ (Agency) to share information regarding my participation in their program(s) for system service coordination. This information will be used to help individuals currently experiencing or at imminent risk of homelessness get the support they need and progress towards stable housing.

By signing this release, I authorize participating organizations to exchange information for the purpose of coordinating services. This may include your name and other identifying information shared by you and 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.

<p>The following agencies listed are excluded from this release <i>(please list all the agencies, if applicable, that you wish to exclude from this agreement)</i></p>	
<p>The following listed agencies/individuals are included in this release <i>and are not included in the list of Partner Agencies listed at https://my.spokanecity.org/chhs/hmis/partners/ but I give permission to this agency to contact them on my behalf</i></p>	

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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.

This release expires 12 months from the date of signature unless revoked earlier (verbally or in writing).

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Agency Signature: _____ Date: _____

Dependent Signature (if over 13 years of age): _____

Dependent Signature (if over 13 years of age): _____

Dependent Signature (if over 13 years of age): _____