TCHSC HMIS Release of Information

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. IF YOU HAVE ANY QUESTIONS OR DESIRE ANY FURTHER INFORMATION REGARDING THIS FORM, PLEASE CONTACT TCHSC HMIS Lead Agency 772-213-9040.

To best serve your needs, to develop meaningful treatment plans, to determine your continuing eligibility for services, and to monitor your progress in complying with the terms of your shelter, housing or other services, Agency and the Continuum of Care need to exchange, share, and/or release data, information or records they may collect about you.

The information contained in your case records with any Agency is considered confidential and privileged and cannot be exchanged, shared and or/released without your express and informed written consent, except where otherwise authorized by law. Please understand that access to shelter, housing and services is available without your consent for the release of the information. However, your consent, although optional, is a critical component of our community's ability to provide the most effective services and housing possible. Every household adult (18+) must have their own signed Release of Information.

I understand that:

- This Agency may not condition the provision of services provided to me based on my signing this consent/authorization (this Agency may not refuse to serve me simply because I do not want my information shared with other agencies), however, I understand that signing this consent does not guarantee services.
- If I give permission, the TCHSC HMIS allows information about me, including my photograph, to be shared with other TCHSC HMIS Partner Agencies. This may include, but is not limited to, my basic identifying information (name, social security number, date of birth, gender, race/ethnicity, marital and family status, household relationships, contact information, veteran status, disability status), history of homelessness and housing, income information and non-cash benefits, legal history/information, self-reported medical history including mental health and substance abuse issues, type of health insurance, service needs and outcomes and emergency contact information. The purpose of sharing information this way is to help the agencies that I seek services from obtain information about me more quickly, assist with my case management, and to help connect me with the services I need.
- Unless I place restrictions, in writing, on the agencies that may see information about me, all TCHSC HMIS Partner Agencies will be able to see the information that this Agency puts into the TCHSC HMIS. Agencies that join the TCHSC HMIS after I sign this consent/authorization also will have access to the personal information that I authorize for data sharing. Upon my request, this Agency must show me a list of the agencies participating in the TCHSC HMIS.
- I understand that I have the right to inspect, copy, and request all records maintained by this Agency relating to the provision of services provided by this Agency to me and to receive a copy of this form. I understand that my records are protected by federal, state, and local regulations governing confidentiality of client records and cannot be disclosed without my written consent unless otherwise authorized by law. I understand that this consent/authorization can be revoked by me at any time in writing by delivering a dated and signed written request to this Agency.
- This form specifically authorizes the use of information about me in research conducted using information maintained in the TCHSC HMIS. I will not be personally identified by name, social security number, or any other unique characteristic in published research reports. The type of research that will be conducted using this information includes reports on the number and characteristics of people using different types of services, the effectiveness of services, and changes in patterns over time.
- I understand that this release will remain in effect for 7 years from the date it is signed, and that consent can be revoked by me at any time by delivering a dated and signed written request to this Agency.

I have read this document, or it was read and/or explained to me, and I fully understand and agree with the terms of this document.

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PRINT CLIENT NAME

_____ _____ _____ _____

SIGNATURE OF CLIENT OR GUARDIAN DATE SIGNATURE OF WITNESS DATE