Authorization to Disclose Client Information

The U.S. Department of Housing and Urban Development (HUD) requires agencies that receive certain types of HUD funding to use a Homeless Management Information System (HMIS). Other funding sources may also require program participation in HMIS. This system is not electronically connected to HUD and is only used by authorized agencies. All persons accessing the HMIS have received confidentiality training and have signed agreements to protect clients' personal information and limit its use appropriately. The HMIS Privacy Policy is available upon request and is posted at the Coalition for the Homeless of Houston/Harris County website (http://www.homelesshouston.org/hmis). Any additional data sharing agreements, providing details on how the member agency handles client information beyond the baseline HMIS Privacy Policy, are available at the agency service sites.

I give permission to the agency listed below to collect and enter information into HMIS about me and my household, which may include demographics, picture, health information, and services that I receive from participating agencies. I understand that the HMIS is shared with and used by authorized agencies in my community for the purposes of:

- Assessing clients' needs in order to provide better assistance and to improve their current or future situations
- Improving the quality of care and service for people in need
- Tracking the effectiveness of community efforts to meet the needs of people who have received assistance
- Reporting data on an aggregate level that does not identify specific people or their personal information

I understand that:

- I have the right to review my HMIS record with an authorized user.
- All agencies that use HMIS will treat my information with respect and in a professional and confidential manner.
- Unauthorized people or organizations cannot gain access to my information without my consent.
- Signing this release form does not guarantee that I will receive the requested services.
- I understand that if I do not sign this form, it will not change whether or not I can receive services from the agency listed below and any other participating agencies. However, I would need to contact each such agency directly to apply for assistance and for a determination of eligibility.
- I understand that this authorization shall remain in effect from the date of my signature below.
- I understand that I may revoke this authorization at any time by notifying the agency listed below in writing. I also understand that the written revocation must be signed and dated later than the date on this authorization. The revocations will not affect any actions taken before the receipt of the written revocation.

My signature below authorizes the agency listed below to release my identity, health conditions when necessary, and my need for services and support to necessary individuals or agencies. Further, if I am unable to participate in a determination of those services, which would be of benefit to me, or my permission is needed in the future to authorize additional services for this program, my signature below authorizes the named individual to sign for assistance for me in my absence after receiving my verbal permission. Finally, if I am unable to make decisions, the person listed below is hereby authorized to represent me:

_____

Agency

_____ _____

Print Name of Designated Individual | Relationship

_____ _____

Client Signature | Date

_____ _____

Witness Signature | Date