Santa Cruz County
Homeless Management Information System

CLIENT INFORMED CONSENT & RELEASE OF INFORMATION AUTHORIZATION

_____ is a Partner Agency in the Homeless Management Information System (HMIS). HMIS is a computerized system that can improve programs for homeless persons by allowing information to be shared among partner agencies that provide services such as shelter and health care and/or homelessness research or administrative services. The system is Internet-based and uses many security protections to ensure confidentiality. Partner agencies currently include:

Adult Protective Services	Wings Homeless Advocacy
Behavioral Health	Association of Faith Communities
City of Santa Cruz	Community Action Board of Santa Cruz
Downtown Streets Team	Department of Veterans Affairs
Employment and Benefit Services	Encompass
Homeless Garden Project	Encompass HOPWA - PRIVATE
Homeless Outreach Proactive Engagement (HOPES)	Families In Transition
Housing Choices	Front St
Janus of Santa Cruz	Homeless Persons Health Project
Mental Health Client Action Network	Homeless Services Center
Mountain Community Resources	Pajaro Rescue Mission
Salud Para La Gente	Pajaro Valley Shelter Services
Santa Cruz Community Health Centers	Salvation Army (Watsonville)
Santa Cruz Public Libraries	Santa Cruz County Human Services Department- CHAMP
Whole Person Care Program	Veterans Resource Center

Participation in the HMIS program is important to our community's ability to provide you with the best services and housing possible. As you receive services, information will be collected about you, the services provided to you, and the outcomes these services help you to achieve. Your name and other identifying information will not be shared with any agency not participating in the system (unless required to do so by law.) Authorizing your information to be entered into the HMIS is voluntary. Refusing to do so will not limit your access to shelter or services.

I give authorization for my basic and relevant information to be entered _____ **(please initial)** and shared _____ **(please initial)** between Partner Agencies in order to help assist me in obtaining permanent housing, employment, financial assistance, vocational services, counseling and medical/mental health treatment and for research and administrative purposes. (Basic information includes intake date, name, social security number, gender, birth date, ethnicity, marital status, number in household, military status, primary language spoken, and non-confidential services requested and received.) I understand that I have the right to receive a copy of all information shared between the Partner Agencies.

I understand that the current list of participating Partner Agencies may change over time to include other agencies who provide housing or services to the homeless population, and I give authorization for my information to be shared with any new Partner Agency._____ **(please initial)**

I understand that I may request a current list of all Partner Agencies at any time. I understand that I may cancel this authorization at any time by written request, but that the cancellation will not be retroactive. I understand that this release is valid for three years from the date of my signature below.

Print Name of Client or Guardian	Signature Of Client Or Guardian	Date

Note: A separate, HIPAA-compliant authorization is required for disclosure of any patient health information, including mental health and drug and alcohol information protected by any State of Federal privacy law including, but not limited to, Health Insurance Portability and Accountability Act ("HIPAA"), 45 C.F.R. parts 160 and 164, California Confidentiality of Medical Information Act ("CMIA"), Civil Code sections 56-56.16, Welfare and Institutions Code section 5328, or 42 C.F.R part 2.1, et seq.