MOSBE: Salinas, Monterey and San Benito Homeless Management Information System

CLIENT INFORMED CONSENT & RELEASE OF INFORMATION AUTHORIZATION

_____ is a Partner Agency in the Homeless Management Information System. HMIS is a shared homeless and housing database system administered by the MOSBE County Continuum of Care. HMIS can improve the services and programs for homeless and low-income households by allowing authorized staff at Partner Agencies to share client information and to follow trends and service patterns over time. HMIS operates over the Internet and uses many security protections to ensure confidentiality.

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).
- Your name, gender, race, social security number, and date of birth may be shared with Partner Agencies for identification purposes even if you elect not to share other relevant information.
- Sensitive information such as diagnosis or treatment of mental health disorders, drug or alcohol disorders, HIV-AIDS, or domestic violence concerns, **will not** be shared between Partner Agencies without specific written consent.
- A list of Partner Agencies is available upon request.
- Authorizing your information to be entered into HMIS is voluntary.
- Refusing to do so will not limit your access to shelter or services.

Please initial one of the following levels of consent:

_____ **(1)** I give authorization for my basic and relevant information to be entered into HMIS and shared between Partner Agencies. I understand I have the right to receive a copy of all information shared between Partner Agencies.

_____ **(2)** I give authorization for my basic and relevant information to be entered into HMIS, but **not** shared between Partner Agencies.

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 or 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 Codes sections 56-56.16, Welfare and Institutions Code section 5328, or 42 C.F.R. part 2.1 et seq.