Continuum of Care FL-507|Homeless Services Network of Central Florida
Client Informed Consent & Authorization for Release of Information in HMIS

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 the system administrator via the HSN HMIS Help Desk by phone (407-893-0133 x120) or by email (hmis@hsncfl.org).

1. In order to best serve your needs at _____ 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, _____ and the Continuum of Care need to exchange, share, and/or release data, information or records they may collect about you.

2. 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 to share information with other service agencies is a critical component of our community's ability to provide the most effective services and housing possible.

3. I understand that:
   a) This Agency may not refuse to serve me simply because I do not want my information shared with other service agencies.
   b) This form specifically authorizes the use of information about me in research conducted using information maintained in the HSN 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.
   c) If I give permission, the HSN HMIS will allow information about me, including records previously entered into the HSN HMIS, to be shared among HSN HMIS Partner Agencies. This may include, but is not limited to, my photograph, information regarding my education history and employment background, income, program eligibility and participation, and personal history. The purpose of sharing information is to help the agencies from which I seek services to obtain information about me faster, to assist with my case management, and to connect me more quickly with the services I need.
   d) Agencies that join the HSN HMIS after I sign this consent/authorization also will have access to the personal information that I authorize for data sharing. This Agency must make reasonable accommodations to allow me to view the updated list of HSN HMIS Partner Agencies.
   e) I understand that I have the right to inspect, copy, and request all records maintained by an Agency relating to the provision of services provided by an Agency to me and to receive a copy of this form unless specifically denied under federal or state law. 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 release is valid for three years from the date I sign this document. I may revoke this authorization at any time verbally or by written request, but the cancellation will not be retroactive.

I give my consent to the exchange of information via the HSN HMIS: Yes ☐ No ☐

☐ 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.

Name and Signature of Guardian	**Name and Signature of Witness**
_____ (print)	_____ (print)
_____ (signature) Date	_____ (signature) Date