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 CoC System Administrators via the CoC HMIS Help Desk by submitting a ticket on our website (https://hmiscfl.org).

1. In order to best serve your needs, to develop meaningful case management plans, to determine your continuing eligibility for services, and to document provision of services, the Continuum of Care (CoC) needs to exchange, share, and/or release data, information or records they may collect about you with other CoC Member Agencies.

2. The information contained in your HMIS records with any Agency is considered confidential and privileged and cannot be exchanged, shared and/or released without your express and informed 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) CoC Member Agencies may not refuse to serve me simply because I do not want my information shared with other service agencies.
   b) Agencies that join the CoC HMIS after I sign this consent/authorization also will have access to the personal information that I authorize for data sharing. All CoC Agencies must make reasonable accommodations to allow me to view the updated list of CoC HMIS Partner Agencies.
   c) 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.
   d) 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.
   e) This release is valid for three years from the date I sign this document. I may revoke this authorization at any time by written request.
   f) Any cancellation of this consent will not retroactively change information that has already been disclosed or actions already taken under your previous authorization.

I give my consent to the exchange of my information, and that of my minor children (if applicable, as listed below), via the CoC 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 Client	**Name and Signature of Witness**
_____ (Print)	_____ (Print)
_____ (Signature) _____ (Date)	_____ (Signature) _____ (Date)

Minor Children (if any):

Client Name: _____ DOB: _____ Last 4 digits of SSN: _____

Client Name: _____ DOB: _____ Last 4 digits of SSN: _____

Client Name: _____ DOB: _____ Last 4 digits of SSN: _____