HMIS CLIENT RELEASE OF INFORMATION

Last Name:	First Name:	Middle Initial:
Provider Completing Assessment:	Date of Birth:	Date of Assessment:

Introduction: Protecting your information is important to us. This document outlines how we use and protect your information. Many Rhode Island shelters and helping programs use the Homeless Management Information System managed by Rhode Island Coalition to End Homelessness (RICH) to keep information about people they help. This form defines which client data is entered into HMIS and how those data are shared between agencies and coordinating groups that meet regularly to identify homeless persons and develop strategies for housing them. A full list of the participating providers in this area can be found on our website https://www.rihomeless.org

The included agencies will collect personal information directly from you and your household to determine your eligibility for services and connect you with other helping agencies. **Agencies only collect personal information that is considered appropriate for getting you housed**. The collection and use of all personal information is guided by strict standards of confidentiality.

We will only use your information to benefit you in the following ways:

- To provide or coordinate services on behalf of an individual or household;
- For payment or reimbursement for services;
- For research projects, as specified in privacy policy
- To carry out administrative functions, including but not limited to oversight and management functions; or
- For creating summary reports without identifying you or confusing you with someone else

SECTION 1 – HMIS Standard Information

Standard information can be seen by all Rhode Island agencies that use HMIS. This information allows us to select the correct record and to better coordinate services for you. All persons using HMIS are trained and certified in privacy.

What information is shared about you in HMIS?

- Name
- Age/ date of birth
- Veteran status
- Gender
- Partial social security number

If you have a privacy concern you can ask to mark your information as private so that only our Agency can see your information.

SECTION 2 – HMIS Data Visibility

Our agency has agreed to share information on clients in HMIS with other agencies. This means that both your historical information and your information collected at this agency will be visible to users from those other agencies in HMIS.

What information is shared about you in HMIS with these other agencies?

- Demographic information (e.g. race, veteran)
- Income and benefit information
- Disability information
- Program enrollment, needs and services
- Homeless history
- Domestic violence status
- Housing assessment (e.g. VI-SPDAT)

SECTION 3 – Coordinating Group

Our agency shares information with several agencies thorough a local coordinating group, designed to coordinate care for you. This means that your information may be discussed verbally, in writing, electronically, or in documents downloaded from HMIS.

Information possibly included in case conferencing:

- Demographic information (e.g. race, veteran)
- Income and benefit information
- Disability information
- Program enrollment, needs and services
- Coordinated entry notes
- Homeless history
- Domestic violence status
- Housing assessment (e.g. VI-SPDAT)

Your Rights:

- Your refusal to share information in this system will not be used to deny you services such as emergency assistance, outreach, shelter, or housing assistance.
- Any information you provide related to race, color, religion, sex, national origin, disability, familial status, and actual or perceived sexual orientation, gender identity, or marital status will not be used in any way that would discriminate against you or prevent you from receiving services or housing assistance. You have the right to file a complaint if you feel that you have been discriminated against
- You may request a copy of this agency's Privacy Notice that explains HMIS and your rights and responsibilities associated with how information is kept and shared through this system.
- You have the right to see your information, request to change it, and to have a copy of that information from the servicing agency by written request. An agency can refuse to change information in your record, but must provide you with a written explanation of the refusal within 60 days of the request. Agencies are allowed to charge for reproducing a record.
- You may withdraw your consent to share at any time by writing to the staff identified in our Agency Privacy Notice. However, any information already shared with another agency cannot be taken back. Your request to discontinue sharing will have to be coordinated between sharing partners. You should tell each agency that you work with when you withdraw your consent.
- The confidentiality of your records is protected by law. This agency will never give information about you to anyone outside the agency without your specific written consent through this release or as required by law (The regulations are the Federal Law of Confidentiality for Alcohol and Drug Abuse Patients, (42 CFR, Part 2) and the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 45 CRF, Parts 160 & 164) and certain Rhode Island laws.

This Release is active for *one year* effective on the date of signature. Data entered historically in the client record will continue to be shared after the expiration of this release of information.

Instructions: *Initial next to the statement that you understand and agree to:*

I agree to have all of my information listed above to be visible to all helping agencies within the groups referenced above.

SECTION 1 – HMIS Standard Information

__ Yes, I agree to share my standard information in HMIS.
__ No, I do not agree to share my standard information in HMIS.

SECTION 2 – HMIS Data Visibility

__ Yes, I agree to share my HMIS information.

__ No, I do not agree to share my HMIS information (Only our agency will see all your detailed information).

SECTION 3 – Coordinating Group

__ Yes, I agree to share my information for coordination of care.

__ No, I do not agree to share my information for coordination of care.

Client signature: _____, Date: _____,

Signature of guardian or authorized-representative (when required): _____

Relationship to client: _____ Date signed by guardian/authorized representative: _____

This release of information also applies to the following dependents:

Last Name	First Name	Date of Birth