Oregon Community CONTINUUM OF CARE

Homeless Management Information System (HMIS)
Informed Consent & Release of Information Authorization

I, (print participant's name) _____ , understand that (Service Provider) _____ collects information about me and/or my dependents listed below to enter it into a database system called Homeless Management Information System (HMIS). This database helps us to better understand homelessness, to improve service delivery to the homeless, and to evaluate the effectiveness of services provided to the homeless. Participation in data collection and release, although optional, is a critical component of our community's ability to provide the most effective services and housing possible. The information that is collected in the HMIS database is protected by limiting access to the database and by limiting with whom the information may be shared, in compliance with the standards set forth by federal, state, and local regulations governing confidentiality of client records. Every person and agency that is authorized to read or enter information into the database has signed an agreement to maintain the security and confidentiality of the information.

BY SIGNING THIS FORM, I AUTHORIZE THE FOLLOWING:

The information gathered and prepared by this agency will be included in a HMIS database of the Oregon Community Continuum of Care (OCCC)'s participating agencies (*list available*), and only to the participating agencies who have entered into an HMIS Agency Participation Agreement and shall be used to:

a. Produce a client profile at intake that will be shared by collaborating agencies
b. Produce anonymous, aggregate-level reports regarding use of services
c. Track individual program-level outcomes
d. Identify unfilled service needs and plan for the provision of new services
e. Allocate resources among agencies engaged in the provision of services

BY SIGNING THIS FORM, I AUTHORIZE THE FOLLOWING:

I authorize the participating agencies and their representatives to share basic information regarding my family members listed below and/or me. I understand that this information is for the purpose of assessing my/our needs for housing, utility assistance, housing counseling and/or other services.

THE INFORMATION MAY CONSIST OF THE FOLLOWING PPI (PROTECTED PERSONAL INFORMATION):

• Name	• Homeless History
• Date of Birth	• Family Composition
• Social Security Number	• Employment Status
• Gender	• Veteran Status
• Ethnicity and Race	• Disabling Condition
• Income and Non-Cash Benefits information	• Domestic Violence
• Housing information	

I UNDERSTAND THAT:

- Information I give concerning physical or mental health problems will not be shared with other participating agencies that have not completed an HMIS Agency Participation Agreement.
- The participating agencies have signed agreements to treat my information in a professional and confidential manner. I have the right to view the client confidentiality policies used by the HMIS participating agencies.
- Staff members of the participating agencies who will see my information have signed agreements to maintain confidentiality regarding my information.
- I understand that participation in data collection is optional, and I may choose to not participate without it disqualifying me from receiving assistance.

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- The release of my information does not guarantee that I will receive assistance, and my refusal to authorize the use of my informational again does not disqualify me from receiving assistance.
- I understand that I may withdraw my consent at any time.
- This authorization will remain in effect until I withdraw my consent in writing, and I may revoke authorization by signing a "Limited Visibility Request", but that cancellation will not be retroactive.
- If I revoke my authorization, all information about me already in the database will remain but will become invisible to all the participating agencies.
- 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 provided for in the regulations.
- Auditors or funders who have legal rights to review the work of this agency, including the U.S. Department of Housing and Urban Development may see my information.
- I understand that my personal information will not be made public and will only be used with strict confidentiality.
- This release is valid for seven (7) years from the date of my signature below.

Participating agencies: A list of the participating agencies within the Oregon Community Continuum of Care (OCCC) System may be viewed prior to signing this form. Information about the OCCC can be found at the website: (oregonbos.org)

List all Dependent children under 18 in household, if any (first and last names):

1.	2.
3.	4.
5.	6.

Please initial one of the following levels of consent:

_____I understand that Protected Personal Information and other relevant information will be entered into the HMIS and shared between participating agencies.

_____I understand that I can choose to limit Protected Personal Information to only the service provider agency listed on this document.

Participant Signature Date

Agency Personnel Name (print)

Agency Personnel Signature Date