

## **Stanislaus County HMIS Client Informed Consent and Release of Information**

The Stanislaus County Homeless Management Information System (HMIS) is a shared database and software application which confidentially collects, uses, and shares client-level information related to homelessness in Stanislaus County. On behalf of the Turlock/Modesto/Stanislaus County Continuum of Care (“CoC”), HMIS is administered by the City of Modesto (City) and Stanislaus’ HMIS Vendor, Eccovia Solutions/ClientTrack. Clients must consent to the collection, use, and release of their information, which helps the CoC’s homeless service providers provide quality housing and services to homeless and low-income people.

Client information is collected in HMIS and released to housing and homeless service providers (each, a “Partner Agency,” and collectively, the “Partner Agencies”), which includes community-based organizations, non-profit organizations and government agencies. Partner Agencies use the information in HMIS: to improve housing and services quality; to identify patterns and monitor trends over time; to conduct needs assessments and prioritize services for certain homeless and low-income subpopulations; to enhance inter-agency coordination; and to monitor and report on the delivery, impact, and quality of housing and services.

Client information is protected by limiting access rights to the database and by limiting the parties to whom the confidential information may be released, in compliance with federal, state, and local regulations governing the confidentiality of client records. Each person or agency with access rights to HMIS, or to whom client information is released, must sign an agreement to maintain the security and confidentiality of client information. Upon any violation of the agreement, access rights may be terminated, and the person or agency found to be in violation of the agreement may be subject to further penalties.

### **BY SIGNING THIS FORM, I AUTHORIZE THE FOLLOWING:**

- I authorize the City, Eccovia Solutions/ClientTrack, the CoC, the Partner Agencies, and their authorized agents and representatives to collect, use, and share basic information about me. I understand that the Partner Agencies may change over time, and that a current list of Partner Agencies has been provided to me. I also understand that I may request a copy of this form be provided to me. This form may not be amended or modified except on approval of the Stanislaus CoC. I understand that I may view an updated list of Partner Agencies at any time or view the list at: [www.modestogov.com/2415/HMIS-Participating-Agencies](http://www.modestogov.com/2415/HMIS-Participating-Agencies).
- I understand that the collection, use, and release of this information is for the purpose of assessing my needs for housing, counseling, food, utility assistance, or other services.
- I understand that I may cancel this authorization at any time by written request, but the cancellation will not be retroactive (No records in the system will be removed from the HMIS databased and will remain accessible to the limited number of organization(s) that provided you with direct services).
- I understand that I have the right to view my HMIS record and will have a report prepared within 10 working days from my written request.
- I understand that if I refuse consent to share this information, I cannot be denied services unless I am being enrolled in an SSVF program.
- This release expires 18 months from the date signed below.

**BY INITIALLING THE BOX BELOW, I FURTHER AUTHORIZE** the following information to be entered into the Stanislaus County HMIS and shared between partner agencies:

Identifying Information: Name, Social Security Number, Date of Birth, Gender, Ethnicity & Race, Marital & Family status, Household Relationships, Phone Numbers, and Address<sup>1</sup> or other similar identifying information. If I do not initial the box below, I do not consent for this information to be entered in the Stanislaus County HMIS.

<b>Client Initial</b>	
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**BY INITIALLING THE BOX BELOW, I AUTHORIZE** the following additional information to be entered in the Stanislaus County HMIS and shared between Partner Agencies to better prioritize my needs and improve the social and housing services provided to me. By initialing the spaces in the two tables below, I authorize that the information or records entered into the Stanislaus County HMIS and shared with Partner Agencies and may include the following specific types of protected personal information (PPI) and protected health information (PHI). If I do not initial the box(es) below, I do not authorize the specific type of information to be shared with Partner Agencies.

- **PHI:**
  - Medical information included in my responses to questions asked as part of the standard HMIS intake.
  - HIV/AIDS-related information included in my responses to questions asked as part of the standard HMIS intake.
  - Mental health information included in my responses to questions asked as part of the standard HMIS intake and identification as a client receiving mental health services from Behavioral Health and Recovery Services or another Partner Agency.
  - Substance abuse treatment information included in my responses to questions asked as part of the standard HMIS intake and identification as a client receiving substance abuse or alcohol treatment from Behavioral Health and Recovery Services or another Partner Agency.

<b>Client Initial</b>	
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- **Additional Information to Improve Service Delivery:**
  - My photograph or other likeness
  - Financial and benefits information (including: employment status, income verification, public assistance payments or allowances, food stamp allotments, health care coverage, or other similar financial or benefits information).
  - Housing information, including history and housing related issues.
  - Information about services provided by HMIS Partner Agencies (including: date, duration, and type of service; and other similar service information)
  - Other (specify): \_\_\_\_\_

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<sup>1</sup> This list of identifying information references the HUD Required Data Elements regarding Basic Demographics.

<b>Client Initial</b>	
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**I UNDERSTAND THAT:**

- My PPI and PHI are protected by federal, state, and local regulations governing the confidentiality of client records. My information cannot be released without my written consent, except to the extent that the regulations provide otherwise.
- Auditors or funders who have legal rights to monitor or review the work of one or more Partner Agencies, including the U.S. Department of Housing and Urban Development, may view my PII and PHI in the ordinary course of their work.
- Eccovia Solutions/ClientTrack serves as the System Administrator for the Stanislaus County HMIS.
- To the extent that authorized agents and representatives of Eccovia Solutions/ClientTrack perform work on HMIS, they may view my information in the ordinary course of their work.
- Partner Agencies and their authorized agents and representatives who use HMIS to research and write reports have signed agreements to maintain the security and confidentiality of client information.
- Use of my likeness in a photograph will be viewable by the Partner Agencies and their authorized agents and representatives. The photograph may be cropped or edited as needed.
- I understand that medical, HIV/AIDS, mental health, and drug and alcohol records are protected under various federal and state regulations, including California Welfare and Institutions Code Section 5328, Confidentiality of Medical Information Act, California Civil Code Section 56.10 (CMIA), the Health Insurance Portability and Accountability Act, 45 C.F.R., parts 160 and 164 ("HIPAA"), and the Federal Regulations Governing Confidentiality of Drug Abuse Patient Records, 42 C.F.R., Part 2, and cannot be disclosed without my written consent unless otherwise permitted by law.
- I expressly authorize my information disclosed pursuant to this Consent to be further disclosed by the recipients listed above for the purposes of assessing my needs for housing, counseling, food, utility assistance, or other services as part of the work of the CoC and HMIS.

**SIGNATURE**

Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM/PM

Signature of Patient/Client or Representative:

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If signed by a person other than the patient/client, indicate relationship:

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Print Name:

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