DISTRICT OF COLUMBIA HMIS UNIVERSAL RELEASE OF INFORMATION
(Please email these forms to: flexfund@housingetc.org)

Participant Last Name:	Participant First Name:	Participant Middle Initial:
Organization Completing Assessment:	Participant Date of Birth:	Participant Social Security Number:

I hereby authorize the use or disclosure of protected health information and personally identifiable information about the individual named above.

I am:

□ the individual named above
□ a personal representative because the patient is a minor, incapacitated, or deceased (complete "Signature of Personal Representative" Section below)

Benefits of sharing your information

- Sharing may reduce the intake time at when you visit a new provider
- Sharing allows agencies to focus on meeting your unique needs more quickly.
- Sharing makes it easier for multiple agencies to coordinate housing and services for you and/or your family.

Information that might be shared

- **Personally Identifiable Information (PII):** Family/household information, name, date of birth, Social Security Number, gender, and race/ethnicity.
- **Protected Health Information (PHI):** History of domestic violence, health information, including diagnoses and treatment for physical and behavioral health conditions (for CAHP purposes only).
- **Other Information:** Reasons for seeking services, living situation and housing history, services you receive, if you are homeless or not, your income and income sources, public benefits you receive, educational background, employment information, military history, housing stability plan.

Please check all that apply:

☐ **SHARE: I consent to have the information collected about me shared through the DC HMIS with other organizations to improve services to me and the services offered to others. These organizations maychange from time to time.** A list of these organizations can be found at community-partnership.org.

☐ **DO NOT SHARE: I do *not* want *my PHI and/or "Other Information" (described above) in* the DC HMIS to be shared with any other service providers/organizations. I understand that not sharing my information may affect the ability to quickly and appropriately identify services for me.**

When you sign this form, it shows that you understand the following.

- **We will *not* deny you help if you do not want us to share your personal information. At the same time, sharing data does not guarantee that you will receive assistance.**

- **If you permit us to share your information, this consent is valid until canceled by you.**
- **If you permit us to share your information, you may change your mind and cancel this consent at any time** by writing to The Community Partnership for the Prevention of Homelessness, at 14 Kennedy Street, NW Washington, D.C. 20011. **If you cancel this consent, your information covered in this release will no longer be shared.**
  If you revoke this authorization, it will not apply to information that has already been used or disclosed.
- If you have any questions about anything on this form, or how to fill it out, please email The Community Partnership for the Prevention of Homelessness, at hmis@community-partnership.org.

☐ **Please treat information about my children age 17 or younger the same as mine.**
☐ **Verbal Consent obtained by phone (update HMIS)**

_____ _____
SIGNATURE OF PARTICIPANT OR GUARDIAN **DATE**

_____ _____
SIGNATURE OF ORGANIZATION WITNESS **DATE**

Signature of Personal Representative (if applicable)

Signature _____ Date (required) _____

Relationship to the individual (required): _

You may be asked to provide us with the relevant legal document giving you legal authority to act on behalf of the individual in making decisions related to healthcare.

NOTICE TO RECIPIENT OF INFORMATION This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

HOUSING COUNSELING SERVICES
AUTHORIZATION TO OBTAIN INFORMATION

I, _____, give my permission to Housing Counseling Services (HCS) to obtain information about me from business entities and persons to determine my eligibility for services I am seeking from HCS. I understand that HCS may contact entities on the list below.

List of Entities HCS May Contact

- Housing providers including property management companies, landlords, real estate agents/brokers;
- Utility companies;
- U.S. Department of Veteran Affairs (including the D.C. VA Medical Center);
- D.C. Government Agencies;
- Social service agencies;
- Employers;
- Businesses in which I am seeking HCS to make a payment on my behalf.
- Any other persons, agencies, and businesses as necessary to determine my eligibility for HCS services.

I give the entities listed above permission to provide and release information about me to HCS. I understand that HCS will treat all of this information as confidential. This release of information expires one year from the date of my signature. My signature below confirms that I have read this authorization or it has been read to me, and I understand its content.

_____ _____
Signature Date

_____ _____
Date of Birth (XX/XX/XXXX) Telephone Number