

HMIS Informed Consent and Release of Information Authorization

This Agency participates in the Snohomish County Homeless Management Information System (HMIS), which is a database that is used to collect information, over time, about the characteristics and service needs of men, women, and children experiencing homelessness or who are at-risk of homelessness. This information is gathered and stored to improve access to services while meeting requirements of funders such as the U.S. Department of Housing and Urban Development (HUD).

To provide the most effective services in moving people from homelessness to permanent housing, we need an accurate count of all people experiencing homelessness in Snohomish County. To make sure that clients are not counted twice if services are provided by more than one agency, and to facilitate care coordination and housing placement services, we need to collect some personal information. Your information will be stored in our database for seven (7) years. This information will be shared with Partner Agencies for the purposes of providing housing placement services. A current list of these HMIS Partner Agencies is available online at <https://snohomishcountywa.gov/756/Homeless-Management-Information-System>. If you have questions about data collection or your rights regarding your personal information, please contact the HMIS System Administrator at 425-388-3270.

By signing this form, I give this Agency permission to share (verbally, or through the HMIS, mail, fax, or by hand) information collected about me and any dependents listed on the back of this form with HMIS Partner Agencies, for the purposes of care coordination and housing placement or retention services, including:

- name, date of birth, gender, race, ethnicity, social security number, phone number, address
- program enrollments and assessments
- housing information
- use of crisis services, hospitals, and jails
- case notes and services provided by Partner Agencies
- basic medical, mental health, substance use and daily living information
- employment, income, insurance, and benefit information

By signing this, I certify I understand that:

- The data I provide will be combined with data from the Department of Social and Health Services (DSHS) for further analysis. My name and other identifying information will not be included in any reports or publications. Only a limited number of staff members in the research division who have signed confidentiality agreements will be able to see this information, and my information will not be used to determine eligibility for DSHS programs. Snohomish County and Washington State HMIS system administrators have full access to all information in the HMIS, including Department of Commerce staff, designated agency system administrators, and applicable HMIS software vendors.
- My decision to participate in the HMIS will not affect the quality or quantity of services I am eligible to receive from this agency, and will not be used to deny outreach, assistance, shelter, or housing. However, if I do choose to participate, services in the region may improve if we have accurate information about homeless individuals and the services they need. Furthermore, some funders **may** require that I consent to my information be supplied in the HMIS in order for me to receive services from that funding source.
- The Snohomish County HMIS guards this information with strict security policies to protect my privacy, using a computer system that is highly secure and uses up-to-date protection features such as data encryption, passwords, and identity checks required for each system user. There may be a risk of a security breach, whereby someone might obtain and use your information inappropriately. If you ever suspect that your data in the HMIS has been misused, and/or to report possible injury arising from the use of such data, immediately contact the HMIS System Administrator at 425-388-3270.

- The purpose of sharing this information with HMIS Partner Agencies is to help with care coordination, improve the services I receive, and allow HMIS Partner Agencies to access information about me quickly if needed.
- I am entitled to a copy of this release and sharing form.
- I may revoke this sharing permission at any time by delivering or mailing a written statement canceling my consent and release of information to this Agency. Revoking my consent/release will not change anything for those people or agencies that had previously received my information while my consent/release was in effect.
- I understand that additional Partner Agencies may join the Snohomish County HMIS and will also have access to this information at that time. I understand that, upon my request, this Agency must provide me with a list of current HMIS Partner Agencies before I sign this release and information sharing form, and must allow me to view the updated list of agencies so long as my release/sharing permission remains in effect.
- I understand that my records are protected under Federal and State Confidentiality Regulations (42 CFR, Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR, 160 & 164) and cannot be disclosed without my written consent unless otherwise provided for in the regulations.
- I understand that my HMIS information may be shared with additional agencies to coordinate referral and placement for housing as well as care coordination.
- This Consent and Release of Information will expire seven (7) years from my last HMIS-recorded activity.
- I have reviewed a copy of the Snohomish County HMIS Client Privacy Rights posted at this Agency.

Note: We are not required to agree to additional restrictions that you request beyond those listed here, but, if we do agree to additional restrictions (that you request in writing), then they are binding on this Agency and on the Snohomish County HMIS.

IMPORTANT: Do not enter personally identifying information into HMIS for clients who are: 1) in DV agencies; 2) currently fleeing or in danger from a domestic violence, dating violence, sexual assault, or stalking situation; or 3) being served in a program that requires disclosure of HIV/AIDS status (i.e., HOPWA). *If this applies to you, STOP – do not sign this form.*

Dependent children under 18 in household, if any (please print first and last name):

CLIENT SIGNATURE (PARENT/GUARDIAN)

DATE

CLIENT NAME (PRINTED)

STAFF NAME (PRINTED)