Client Release of Information

for the San Antonio / Bexar County Continuum of Care's Homeless Information Management System

To provide you with the most effective and efficient service, we must collect relevant data for our Homeless Management Information System (HMIS). This secure and confidential database operated by trained representatives allows service providers to work together with you to make sure you are receiving the assistance you need in a timely manner. Beyond that, the HMIS allows the CoC to get an accurate count of all individuals experiencing homelessness or who are at risk of homelessness in San Antonio/Bexar County. To help us improve our current service system, coordinate services, and make plans for new services, we need to collect your personally identifiable information (PII). To better coordinate with other service providers, you have the right to consent to release your information to these other service providers.

Please review the information below and sign and date where indicated. *[Note to staff, if working with a family, please complete the back of this form as well].*

I understand and agree that this service provider will enter my information into the Homeless Management Information System (HMIS). The information I have provided is true and correct. I understand that my information may be shared among local service providers for the purpose of connecting me to services.

I understand that information about me that is in HMIS may be used by the service provider and the San Antonio / Bexar County Continuum of Care, including but not limited to, to conduct research and develop reports related to homelessness and housing programs, coordination of care, housing, service needs, income supports, education and employment, and program effectiveness. I authorize the collection of information, including PII, about the services provided to me and for this information to be included and shared with service providers in HMIS. I further understand that some of the information collected and shared may include records that are considered Protected Health Information under the Health Insurance Portability and Accountability Act (HIPAA). I understand that should I no longer want my information collected and shared, I may withdraw my consent in writing at any time by contacting: [Insert email address for Agency Security Officer]. Any information shared or collected prior to withdraw of consent cannot be revoked.

An agency representative has answered my questions about my privacy concerns. By signing this release form, I fully understand and agree to the above terms and conditions.

CLIENT NAME [PRINT]	DATE	CLIENT SIGNATURE	DATE
AUTHORIZED PERSONNEL NAME [PRINT]	DATE	AUTHORIZED SIGNATURE	DATE

1234 Anywhere Avenue

(XXX)XXX-XXXX

SampleEmail@sample.org

Client Consent on Behalf of Household Members

An adult head of household may provide consent on behalf of family members to share their information in the HMIS.

FAMILY MEMBER NAME 1 [PRINT]	HEAD OF HOUSEHOLD [INITIALS]
FAMILY MEMBER NAME 1 [PRINT]	HEAD OF HOUSEHOLD [INITIALS]
FAMILY MEMBER NAME 2 [PRINT]	HEAD OF HOUSEHOLD [INITIALS]
FAMILY MEMBER NAME 3 [PRINT]	HEAD OF HOUSEHOLD [INITIALS]
FAMILY MEMBER NAME 4 [PRINT]	HEAD OF HOUSEHOLD [INITIALS]
FAMILY MEMBER NAME 5 [PRINT]	HEAD OF HOUSEHOLD [INITIALS]
FAMILY MEMBER NAME 6 [PRINT]	HEAD OF HOUSEHOLD [INITIALS]
FAMILY MEMBER NAME 7 [PRINT]	HEAD OF HOUSEHOLD [INITIALS]