**“Fill in CoC or County” included” NC HMIS**

**CLIENT RELEASE OF INFORMATION & SHARING PLAN**

**SECTION 1 - Identifying Information**

**Introduction**: Many North Carolina shelters and helping programs use the North Carolina Homeless Management Information System (NC HMIS) to keep information about people that they help. We collect personal information from you that we need to help us help you. We have strict rules about sharing your information.

**Why do we collect information about you?**

* Work with other agencies to help you
* Help case managers work together for you

Connect you with other helping agencies. You may be eligible for other benefits.

* Reduce the number of times you have to tell your story
* To allow agencies to be paid for their work with you and to help them apply for additional dollars that can be used to help you.
* To help agencies meet their legal obligations.

We need additional identifying information to insure your information is not confused with someone else. We also need to learn more about your situation to make sure you are eligible for services.”

**What basic identifying information is collected about you?**

* Your name
* Your gender
* Your Social Security Number
* Your date of birth

**Finding your Information on the HMIS?**

**Basic identifying information** (name, year of birth, **partial** Social Security Number and gender and your veteran status) can be seen by all North Carolina agencies that use HMIS. This information allows us to select the correct record and to better coordinate services for you. All persons using HMIS are trained and certified in privacy.

If you have a specific privacy concern you can ask to close this information so that only our Agency can see this information. Please initial here \_\_\_\_\_\_.

**SECTION 2 – Coordination of Care Sharing Plan**

Many agencies also use the System to improve services to you through coordination of care. If you are receiving services from multiple agencies that participate in the System, agreement to the Sharing Plan defined below allows for these Agencies to see your information. You will only have to sign this release once and it applies to all Agencies listed below in “The Plan”.

**Your Rights (Instructions)** Put your initials next to the statements that you understand and agree to:

|  |  |
| --- | --- |
| \_\_\_ | I have received a copy of this Agency’s Privacy Notice/script that explains NC HMIS and my rights and responsibilities associated with how information is kept and shared through this system. |
| \_\_\_ | I understand that my written consent allows the information listed in the Sharing Plan to be shared among the agencies listed in the Sharing Plan. All sharing agencies where I am receiving services may update that information as I provide additional or new information. The purpose of sharing my information is to better coordinate care for me and my family. |
| \_\_\_ | I understand that the confidentiality of my records is protected by law. I understand that this agency will never give information about me to anyone outside the agency without my specific written consent through a Sharing Plan or as required by law (The regulations are the Federal Law of Confidentiality for Alcohol and Drug Abuse Patients, (42 CFR, Part 2) and the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 45 CRF, Parts 160 & 164) and certain North Carolina laws. |
| \_\_\_ | I understand that Agencies included in my Sharing Plan must follow strict privacy guidelines.  |
| \_\_\_ | I can withdraw my consent to share at any time; however any information already shared with another agency cannot be taken back. I also understand that the request to discontinue sharing will have to be coordinated between sharing partners. I should tell any agencies that I am seeing included on the Plan when I withdraw my consent. |
| \_\_\_\_ | I understand that I have the right to see my information, request to change it, and to have a copy of that information from the servicing agency by written request. An agency can refuse to change information in my record, but must provide me with a written explanation of the refusal within 60 days of the request. Agencies are allowed to charge for reproducing a record. |
| \_\_\_ | I understand that the refusal to share information in this system will not be used to deny me services such as emergency assistance, outreach, shelter, or housing assistance.  |
| \_\_\_\_ | I understand that some of my information may be disclosed for academic research purposes without identifying information included. My name and other identifying information may be used to match records but will not be released to be used directly in the research unless I sign a separate consent when identifying information is a requirement for the Study (example: so a researcher can contact me). |

**Description of Information Shared through the Coordination of Care Plan** (*Box below based on Sharing QSOBAA*)

|  |  |  |
| --- | --- | --- |
| Your race | Homeless status | Disability |
| Your family members | Type of housing | Medical information |
| Your phone numbers | Household income | Mental health |
| Your address | Domestic violence history | Substance abuse |
| Marital status | Reasons for homelessness | Pregnancy status |
| Military veteran status | Employment information | Services provided |

**This information** (listed above) can be seen by all the agencies listed below to help coordinate your care. Any of these agencies can share your information with each other.

|  |  |
| --- | --- |
| * ABC Agency
 | * DEF Agency
 |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Instructions:** Check the box next to the statement that you understand and agree to:

I agree to have all of my information visible to all helping agencies listed above.

* 1. **□** Yes, I agree to share according to the Sharing Plan.
	2. **□** No, I do not agree to the Sharing Plan (Only our agency will able to see all your detailed information.

|  |
| --- |
| **This Release is active for one year effective the date of Signature.** Client signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,Signature of guardian or authorized-representative (when required): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date signed by guardian/authorized representative: \_\_\_\_\_\_ |