

Housing First Solano HMIS Client Consent to Data Collection and Release of Information

**THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND
DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.**

The Housing First Solano 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 Solano County. On behalf of the Housing First Solano Continuum of Care (“CoC”), HMIS is administered by the Community Action Partnership Solano Joint Powers Authority (“CAP Solano JPA”) and Pathways MISI. Clients must consent to the collection, use, and release of their information, which helps the CoC to provide quality housing and services.

Client information is collected in HMIS and released to licensed users from authorized housing and services providers (“Partner Agency,” and collectively, the “Partner Agencies”), which includes community-based organizations and government agencies. Partner Agencies use the information in HMIS: to improve the quality of housing and services; to identify 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 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.

If clients are currently fleeing from domestic violence, they have the right to access specific resources for survivors. These programs do not collect data in the HMIS.

Clients have the right to refuse to share data with HMIS. While clients cannot be denied services on the basis of a refusal to consent to participate in HMIS, it may be more difficult to connect clients to appropriate services.

AGREEMENT TO EXECUTE USING ELECTRONIC SIGNATURE:

I understand and intend that my electronic signature and electronic initials on this form shall have the same force and legal effect as if signed or initialed with an original ink signature. I represent, warrant, and agree that my signature and initials, whether in electronic or original ink, shall give rise to a valid, enforceable, and fully effective consent and agreement.

BY SIGNING THIS FORM, I AUTHORIZE THE FOLLOWING:

- **I authorize CAP Solano JPA, 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 an updated list at any time or view the list at: <http://www.housingfirstsolano.org/hmis-participating-agencies.html>. 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.
- By initialing one or more of the space(s) in the table below, I authorize that the information or records entered into HMIS may include the following specific types of protected personal information (“PPI”) and protected health information (“PHI”). If I do not initial one or more space(s) in the table below, I do not authorize the specific type of information to be share via HMIS:

Client initials	Type of PPI/PHI
	Identifying information (including: name, birth date, gender, race, ethnicity, social security number, phone number, residence address, or other similar identifying information)
	My photograph or other likeness

	Medical information included in my responses to questions asked as part of the standard HMIS intake and identification as a client or patient of health related program
	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 or identification as a client receiving mental health services from the County’s Behavioral Health Services or behavioral health services contractors
	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 the County’s Behavioral Health Services or behavioral health services contractors
	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
	Information about services provided by HMIS Partner Agencies including: date, duration, and type of service; and other similar service information
	Other (specify): _____

BY SIGNING THIS FORM, I UNDERSTAND THAT:

- I authorize Partner Agencies and their authorized agents and representatives to use the PPI and PHI collected in HMIS to prioritize me for and refer me to housing and services. I further authorize the Partner Agencies and their authorized agents and representatives to communicate with other Partner Agencies and their authorized agents and representatives about my case for the purposes of coordinating prioritization and placement and determining eligibility for housing and services.

- The Partner Agencies and their authorized agents and representatives individually have signed agreements to maintain the security and confidentiality of my information. I have the right to review all applicable confidentiality policies and signed agreements.
- **I understand that I may refuse to sign this Consent.** My refusal will not affect my eligibility for benefits or services, or my ability to obtain treatment or payment. In addition, consenting to the release of my information does not guarantee that I will receive services, and my refusal to consent does not disqualify me from receiving services. I have a right to receive a copy of this authorization.
- I may revoke this Consent at any time, but I must do so in writing. This Consent may be revoked verbally for records relating to drug/alcohol treatment or mental health treatment.
- If I revoke this Consent, the revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Consent.
- 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 PPI in the ordinary course of their work.
- Pathways MISI serves as the System Administrator for HMIS and the software vendor is Clarity. To the extent that authorized agents and representatives of these agencies 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.
- 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 understand that some information shared under this consent may be re-shared with others under certain conditions and may no longer be protected by State and Federal confidentiality laws.
- 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.
- If I have questions about my information, my rights regarding that information, or am concerned that my information has been misused, I can contact Housing First Solano at admin@capsolanojpa.org.

SIGNATURE

Name of Client: _____

Signature of Client or Representative: _____

If signed by a person other than the client, please indicate relationship: _____

Date of Signature: _____ Time of Signature: _____AM/PM

This Consent will expire:

- **In seven years from date of signature; INITIAL: _____ OR**
- **on [insert date] _____ . INITIAL: _____**

This consent is not valid if an expiration date is not included.