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Coordinated Entry Partnership

Release of Information

# PERMISSION TO SHARE PERSONAL & HEALTH INFORMATION TO SECURE HELP WITH HOUSING

## A staff member will review this form with you. Signing is voluntary.

**Each adult in a household must sign their own permission form.**

**Name of Individual: \_ DOB: \_ Last 4 of SSN:**

## A Parent/Legal Guardian may complete a release for one or more children at a time.

|  |  |  |
| --- | --- | --- |
| **Name of Child (if applicable): \_** | **DOB:** | **Last 4 of SSN:** |
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**Name of Parent/Legal Guardian (if applicable):**

\_ has agreed to participate in the VT Balance of State (VT BoS) Coordinated Entry Partnership. The VT BoS Coordinated Entry Partnership includes organizations that provide homeless and housing assistance. As part of the VT BoS Coordinated Entry Partnership, agencies agree to share information about individuals and families with other agencies in the Partnership in order to help a household to find or keep housing as quickly as possible.

# HOW IT CAN HELP YOU WHEN YOU LET AGENCIES SHARE YOUR INFORMATION

|  |  |
| --- | --- |
| **Reduces the amount of time spent answering basic questions about your situation** | **Reduces the amount of times you have to tell your story to service providers** |
| **Faster access to services and housing help** | **Allows agencies to focus on meeting your unique needs** |
| **Eliminates duplicate intake paperwork** | **Multiple services can be better coordinated** |

* **I give my permission for the homeless and housing service agencies participating in the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Local CE Partnership, except for the following agencies:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*The list of participating agencies is attached.*

**To communicate with and disclose to one another the following information (check all that apply):**

* Personal Identifying Information: Name (First, Middle and Last), Social Security Number, Date of Birth, Ethnicity, Gender, Last Residence Information, Military Status
* Information about my housing status and barriers to stable housing, including income, non-cash income, history of domestic violence, evictions, debt, legal issues, etc.
* Information about my enrollment in services related to housing or other homeless assistance programs
* Information about the services my household receives from housing or homeless assistance programs: referrals, assessments
* Information about my physical and/or mental health condition(s), such as any disabilities or chronic medical conditions
* Information about my alcohol/drug related diagnosis, treatment or referral for treatment, and HIV status (as limited as possible). No information about a child's substance use disorder will be shared.
* Other \_\_\_\_\_\_\_

## The purpose(s) of the disclosure authorized is:

* To determine the services that are necessary for me
* To facilitate obtaining resources to support my housing and related needs
* To coordinate services on my behalf and prevent duplication
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## By signing this form, I understand:

* The reason(s) I am being asked to release information.
* Signing this authorization is voluntary. I understand that ability to receive services or support is not conditioned upon authorizing this disclosure. However, by not giving authorization to share information, I may not be able to access housing help as quickly as possible. Also, some agencies may require that you answer certain questions to make sure that you are eligible for services.
* While will take every precaution to protect my personal and health information, once it is released pursuant to this authorization, it may be subject to re-disclosure by other parties.
* My drug and alcohol treatment records and HIV status are protected by Federal confidentiality rules (42 CFR Part 2; HIPAA) and cannot be disclosed or re-disclosed without my express written consent or as allowed by the regulation. I am authorizing

to share information about my alcohol or drug related diagnosis, treatment or referral for treatment, and HIV status. By signing this form, I also authorize subsequent or re-disclosure of this information, if applicable, among the homeless and housing service agencies. By checking the box below, I signify that:

I do not consent to re-disclosure of information concerning alcohol or drug related diagnosis, treatment or referral for treatment, and HIV status.

□

* I may revoke this authorization at any time by contacting at , except to the extent that it has been acted upon.
* If I do not revoke or update this authorization, it will be in effect for 3 years from the date below.
* I will be provided a copy of this form.
* All items on this form have been completed and my questions about this form have been answered.

|  |
| --- |
| **Signature of Individual or Parent/Legal Representative Date** |
| **Name of Person Explaining Authorization Process Organization / Position Date** |

***Reminder:*** *must complete a separate release of information to share data in the Homeless Management Information System (HMIS). That release can be found here:* [*https://helpingtohousevt.org/wp-content/uploads/2024/02/DRAFT-VT-Statewide-HMIS-ROI.pdf*](https://helpingtohousevt.org/wp-content/uploads/2024/02/DRAFT-VT-Statewide-HMIS-ROI.pdf)