PA HMIS Collaborative Client Consent
Release of Information via PA HMIS

The Pennsylvania Homeless Management Information System ("PA HMIS") serves the Pennsylvania Continuums of Care Collaborative, a group of agencies ("PA HMIS Participating Agencies") working together to provide services to individuals and families in Pennsylvania who are homeless or at risk of becoming homeless. In an effort to end homelessness, PA HMIS allows the Commonwealth of Pennsylvania and PA HMIS Participating Agencies to use this system to efficiently collaborate, identify, coordinate, and evaluate individual services needed. The PA HMIS is also used to produce nonidentifying, aggregate reports that can be used to track program performance which is necessary to receive program funding from the federal government, identify unfilled service needs, and plan for new service provision.

This process is beneficial to improving your case management and received services, as well as assisting PA HMIS Participating Agencies to locate multiple housing or service options. Additionally, sharing information between PA HMIS Participating Agencies can reduce the number of times you are asked for repeated information. By consenting to share this information with participating agencies, you will allow PA HMIS to provide better coordination between PA HMIS Participating Agencies in an effort for you to obtain and maintain permanent housing.

Information collected in the PA HMIS database is protected in compliance with the standards set forth in the Health Insurance Portability and Accountability Act (HIPAA). Every person and agency that is authorized to read or enter information into the database has signed an agreement to maintain the security and confidentiality of your information. Any person or agency that is found to violate their agreement may have their access rights terminated and may be subject to further penalties including legal action.

I UNDERSTAND THAT:

- In an effort to end homelessness and to better serve me and/or my family, the PA HMIS Participating Agency identified at the bottom of this form will collect and may share my identifying information with other PA HMIS Participating Agencies via PA HMIS.

- The intention and purpose of collecting and sharing my information is to help PA HMIS Participating Agencies better understand and assist my/our needs, and to produce non-identifying, aggregate reports to the federal government that can be used to track the program performance of these agencies.

- The PA HMIS participating agencies have signed agreements and are bound to implement policies to maintain my information in a secure and confidential manner, as mandated by Federal and State laws.

- The release of my information does not guarantee that I will receive assistance. Alternatively, refusing to release my information will not affect my opportunity to receive assistance.

- This authorization will remain in effect for a period of up to 7 years or until I revoke it in writing. I may revoke authorization at any time by returning to any previously visited PA HMIS Participating Agency and signing a new consent form using the "I do not agree" option. If I revoke my authorization or this authorization expires, all information about me already in the database will remain to retain usage history; however, it will be inactive and not updated. I further understand that any revocation of this consent will not affect the waiver of confidentiality as to information already disclosed.

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- If I decline to release my information, it will be hidden from all other PA HMIS participating agencies, except in the case of a referral. If I need to be referred to another agency for services, my information will be forwarded to only that agency, regardless of my recorded data sharing preference.

Please choose an option:

☐ I **agree** to allow sharing of my information via the PA HMIS system with PA HMIS participating agencies.

☐ I **do not agree** to allow sharing of my information via the PA HMIS system with PA HMIS Participating Agencies. I understand that if I need to be referred to another agency, only the data necessary to complete the referral will be forwarded.

_____   _____ _____
Client Name   Client Signature   Date
(*Please print*)

_____   _____ _____
Guardian Name, if applicable   Guardian Signature, if applicable   Date
(*Please print*)

List Dependent(s) Name(s), if applicable

(Note: If dependents are not presenting for services at the same time as the guardian, or the guardian wishes to record different individual consent responses, use a separate consent form for each dependent.)

_____

_____

_____
PA HMIS Participating Agency Name (*Please print*)

_____   _____   _____
Agency Personnel   Agency Personnel Signature   Date
(*Please print*)