



**Homeless Alliance for the Lower Shore
Homeless Management Information System**

AUTHORIZATION TO RELEASE OR OBTAIN INFORMATION

Client's Personal Identifying Information:

Name: _____ Birth Date: //

SSN: _____ Phone _____ Sex: Race: _____

Present Address: _____

Former Name (if applicable) _____

In signing this release I authorize the following agencies to share my personal information entered into HMIS for the purposes of improving services to those members of our community who are experiencing homelessness, or who are at risk of homelessness in Wicomico, Worcester and Somerset Counties and the City of Salisbury. Agencies participating in HMIS include but are not limited to: Christian Shelter, Village of Hope, HALO, CESP, HOPE, Inc. Camp Royal Oak, Diakonia, Samaritan Ministries, Second Chance Help, Inc., RAHTS Ministry Shelter, Joseph House, Salvation Army, each county Department of Social Services, each County Health Department, City of Salisbury, St James AME Zion House Church, Telemon and Catholic Charities - Seton Center. I understand that information obtained by these agencies will be entered into the Homeless Alliance for the Lower Shore Program (HALS) Homeless Management Information System (HMIS).

I request and authorize that the following personal information be provided. Demographic Information (age, race, address, etc) Household Information Disability Information Services Needed and Obtained Shelter Stay Length of homelessness Income Information Non Cash and Health Insurance Benefits Other Information , please specify

Except for the following which expressly may NOT be disclosed (If none, write "NONE"):

If the information which a program has includes records or information from another entity,

I DO or DO NOT wish to have that information released under this authorization. No service will be withheld if you do not authorize release of information attained by a program from another agency.

Conditions For Exchange of Authorized Information

Expiration: **This authorization will expire two years from date below unless revoked in writing:**

DATE //

RIGHT TO REVOKE: I understand that I may revoke this authorization at any time by giving written notice in good faith. (CRIMINAL JUSTICE SYSTEM REFERRALS – RULES: “Revocation of consent” An individual whose release from confinement, probation, or parole is conditioned upon his participation in a treatment program may not revoke a consent given by him in accordance with paragraph (a) of this section until there has been a formal and effective termination or revocation of such release from confinement, probation or parole.” FEDERAL REGISTER, VOL 40, No 127, TUESDAY, July 1, 1975.)

USE SPACE BELOW ONLY IF CLIENT REVOKES CONSENT

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Date Consent Revoked by Client

Signature of Client

CONFIDENTIALITY: If the request for information concerns a person’s treatment of alcohol or drug abuse, the confidentiality of this information is protected by federal law: (42CFR Part 2) which prohibits any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A General Authorization for the release of medical or other information is NOT sufficient for this purpose.

REDISCLOSURE: Any individual or agency receiving Homeless Alliance for the Lower Shore (HALS) client information is prohibited from making further disclosure of the medical record based on this authorization. This is prohibited as provided by the annotated Code of Maryland 4-303 (b) (5) (ii).

PHOTOSTAT/FACSIMILE: A photostat or facsimile of this authorization is considered as effective and valid as the original.

Signature of Client

Date

Signature of Guardian or Legal Representative

Date

Relationship to Client: _____ (Attach copy of document granting legal authority)

Signature of Witness (Agency Staff)

Date

Signature of Counselor (if applicable)