KANE COUNTY Homeless Management Information System (HMIS)

CLIENT INFORMED CONSENT AUTHORIZATION FOR RELEASE OF INFORMATION

_____	_____	_____
CLIENT NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH

I hereby authorize _____, a participating member of the Kane County Continuum
(Agency Name)
of Care and its HMIS (Homeless Management Information System), to disclose all of the following information:

(Sign your initials next to information you DO NOT wish to be shared.)

____ Name	____ Race	____ Veteran Status
____ Social Security Number	____ Ethnicity	____ Date of Birth
____ Type of Residence Prior to Entry	____ Disability Status/Condition	____ Gender
____ Length of Stay at Prior Residence	____ Zip Code of Prior Residence	____

I understand that such information shall only be released to these other Kane County Continuum Members:

Community Crisis Center	Ecker Center	Hesed House/PADS, Inc.
Hope For Tomorrow	Lazarus House	Midwest Shelter for Homeless Veterans
PADS of Elgin	Wayside Cross	

AND the technical support team for the HMIS software used by the Kane County Continuum of Care (and any new agencies that join the KANE COUNTY HMIS).

I understand it is necessary to share this information to prevent duplication of data and services. I also understand that other statistical components of services I receive are entered in to the HMIS system and reported to HUD (U.S. Department of Housing and Urban Development) on a consolidated basis (without identifying individuals served) as required for funding. I also understand:

- My decision to not disclose information through HMIS will not affect the quality or quantity of service I am eligible to receive from this agency and will not be used to deny outreach, shelter or housing; however, I do understand services in the region may improve if accurate information is provided.
- I may revoke this consent at any time, but that there may have been information shared and services provided based upon this consent when it was in effect. Ending this consent cannot change that.
- Any notice by me to end this consent must be in writing.
- This consent will automatically expire 1 year from the date I sign this consent.
- The entities specified above are released from any legal responsibility or liability for disclosure of the information described above and as authorized by my signature below, and information may be disclosed to other agencies to assist in obtaining requested services.
- A copy or facsimile (FAX) of this consent may be utilized in place of the original signed consent.

This consent has been explained to me. I have read it (or it was read to me) and understand its provisions. I have been given a reasonable amount of time to ask questions and consider whether to permit the sharing of the designated information. I hereby willingly agree to the sharing of that described information on myself and any dependents listed below.

Dependent children under 18 in household, if any (first and last names):

_____ _____

_____ _____

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____
(Second Adult if Any)

Witness Signature: _____ Date: _____