# Coordinated Access for Adults and Families: Authorization for Disclosure of Confidential Information

Client Name: _____ Date of Birth: _____/_____/_____

**Coordinated Access for Adults and Families** is a network of agencies formed with the purpose of coordinating the delivery of services to provide long-term rental assistance and supportive services to individuals and families who are homeless with priority for those with the longest history of homelessness and most service needs. A full list of Coordinated Access for Adults and Families partner agencies is available upon request and published online at ahomeforeveryone.net/coordinatedaccess.

Coordinated Access for Adults and Families will enter the information you provide us into a vendor-hosted Homeless Management Information System (HMIS), a computerized and secured record-keeping system known as ServicePoint. We are required by law to maintain the privacy of your personal identifying information. Your information will not be shared electronically with other agencies without your permission.

**By signing this form, I agree to** share my Client Record [Name, Social Security Number, and Veteran Status], Demographics [Date of Birth, Gender, Race, and Ethnicity], Coordinated Access for Adults related Program Enrollment and Exit Information, information about the nature of my situation, and Services and Referrals I receive, with Coordinated Access for Adults and Families partner agencies.

***Specially Protected Health Information That Can Be Exchanged or Disclosed:***

A. I recognize that the information released may contain information regarding mental health treatment that is protected by state law *(ORS 179.505 & 192.505, 45 CFR 205.50)*; and I specifically consent to its release. Initial: _____

B. I specifically authorize the above Authorization to disclose information to include any alcohol/drug diagnosis, treatment, and treatment referral. I understand that any disclosure made is bound by *Part 2* of *Title 42* of the *Code of Federal Regulations (CFR)* governing confidentiality of alcohol and drug abuse patient records. Recipients of this information may disclose only with my written consent or as permitted by *42 CFR Part 2*. Initial: _____

C. I specifically authorize this Authorization for release of information to include any HIV (AIDS) information. Initial: _____

I understand that this information may include material that would otherwise be protected by Oregon law. All Coordinated Access for Adults and Families participating agencies acknowledge that any information shared among these agencies will not be released to other parties without my further written authorization. Relevant disclosures made may be bound by Part 2 of Title 42 of the Code of Federal Regulations (CFR) governing confidentiality of alcohol and drug abuse patient records and by Health Insurance Portability and Accountability Act (HIPAA) privacy rules in 45 CFR 160 and 164.

**This authorization becomes effective on the date below and will expire 12 months from my last date of participation in Coordinated Access for Adults and Families; a period reasonably needed to complete the disclosure of information for the purposes described and named in this authorization unless I indicate otherwise.** ☐ Specific expiration date: _____.

I understand that I may revoke this authorization at any time except to the extent that action has already been taken in reliance on it. Revocation of this authorization is effective upon receipt by Coordinated Access for Adults and Families of my written notice of revocation.

I understand that I may refuse to sign this authorization, and that my refusal will not affect my ability to obtain treatment, payment, or my eligibility for benefits. I understand that refusing to sign this may affect my engagement with Coordinated Access, shared prioritization lists, and access to partner agencies. I may inspect or copy any information used and/or disclosed under this authorization. My signature below indicates I approve of this authorization and understand its meaning.

| _____ | _____ | _____ |
|---|---|---|
| **Signature of Client or Legal Guardian** | **Date** | **Signature of Witness** |

**My signature here indicates I revoke this authorization: _____ Date: _____**