



**Watsonville/Santa Cruz City & County Continuum of Care (CoC)
HMIS CONSUMER INFORMATION SHARING AUTHORIZATION FORM**

This Organization participates in the Housing for Health Partnership (Watsonville/Santa Cruz City & County) CoC Homeless Management Information System (Watsonville/Santa Cruz CoC HMIS).

The Watsonville/Santa Cruz CoC HMIS is used to collect basic information about consumers receiving services from this and other Organizations. This helps: 1) Local Organizations get a more accurate count of individuals and families experiencing or at-risk of homelessness; 2) Identify the need for different services and housing resources in the community; 3) Connect individuals and families at-risk of or experiencing homelessness to the services and housing resources they need; and 4) Secure funding from agencies that request this data as a funding requirement.

The CoC and participating Organizations only collect information that is considered appropriate and necessary. The collection and use of all personal information are guided by strict standards of privacy and security. Every person and agency that is authorized to read or enter information into the HMIS database has signed an agreement to maintain the security and confidentiality of every consumer.

The Protected Personal Information (PPI) and other general information gathered may include, but is not limited, to the following:

Name	Program Start/End Dates	Domestic Violence
Date of Birth	Housing History	Legal History
Social Security Number	Employment Status	Substance Abuse*
Gender	Family Composition	Mental Health*
Ethnicity and Race	Veteran Status	Photo (if applicable)
Zip Code of Last Permanent Address	Medical history and conditions*	

*My information, especially my medical, mental health, and substance abuse history, cannot be released outside of the HMIS provider network without my further written consent, unless otherwise allowed by the regulations.

By signing this Authorization Form, I understand the following:

- This consent will be valid for 3 years from the date listed below.
- My Protected Personal Information (PPI) is protected by federal, state, and local laws governing confidentiality.
- I may sign this consent form, but I have the right to agree to share only certain or specific information upon my request.
- I may receive services, even if I do not sign this consent form. Providers may not refuse to provide me with services based on my refusal to sign this form, nor will it affect my eligibility for benefits or other supports.
- I may receive a copy of this consent form and the CoC Privacy Policy upon request.
- I have the right to review and receive a copy of my HMIS record, to correct my record, or file a statement of disagreement at any time.
- I may revoke (withdraw) this Consent at any time, but I must do so in writing or by using the Revocation Form. Upon revocation, the CoC will remove my PPI from the HMIS database, but information and data previously obtained cannot be removed entirely.

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I have the right to file a grievance against any organization whether I signed this consent or not if I think my privacy rights have been violated. The Grievance Form must be made available or provided to me upon request.

This Organization may use or disclose information without permission from the Watsonville/Santa Cruz CoC HMIS under the following circumstances:

- To provide or coordinate services and housing resources for an individual or families
- For functions related to payment or reimbursement for services or housing resources
- To carry out administrative functions
- When required by law, including a court order
- For research and/or evaluation purposes
- For creating de-identified (anonymous) data

Please note HMIS policies and laws may change over time and effect the use of data retroactively.

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SIGNATURE AND ACKNOWLEDGEMENT OF THE HMIS CONSUMER INFORMATION SHARING AUTHORIZATION FORM

By signing this consent form, I authorize the HMIS participating organizations and their representatives to share Protected Personal Information regarding myself and/or my family members for the purposes of assessing my/our needs for housing, utilities, assistance, food, counseling, and/or other supportive services. I have read (or been read) this Consumer Authorization Form, have had the opportunity to ask questions and receive answers to my questions, and I freely consent to having my information (and of any children) entered into the HMIS database.

I acknowledge that I have received a copy of the HMIS Consumer Authorization Form of the Housing for Health Partnership CoC.

OR

Consumer Name (Please Print)

Name of Personal Representative

Consumer Signature

Signature of Personal Representative

Date

Relationship to Consumer

Date