



HSH Permanent Housing Application

Form A: Homelessness Response System Authorization for Use or Disclosure of Information [to be completed by Client and Staff]

Printed name of Client: (Head of Household/Primary Applicant)	
Client's Date of Birth: (Head of Household/Primary Applicant)	

This form and the attached notice describe how personal information about you may be used and shared by the City and County of San Francisco's Department of Homelessness and Supportive Housing (HSH) and its Partner agencies, and the rights you have about your information.

The San Francisco Department of Homelessness and Supportive Housing's (HSH) Online Navigation and Entry (ONE) System (the City's Homeless Management Information System) is a database that allows HSH to save, access, and share client level information with our Partner agencies, which are San Francisco City Departments, including the Department of Public Health and the Human Services Agency, and other community-based housing and service providers who work with people experiencing, or at risk of experiencing, homelessness. Examples include the SF Homeless Outreach Team (SFHOT) or service providers in supportive housing.

To be able to best help you, information is collected in the ONE System and used by or shared with Partner agencies. Partner agencies use the information in the ONE System to:

- Match clients to appropriate housing and other services they might be able to receive
- Improve coordination of your care and related services between City agencies and providers; and
- Continue to look at ways to improve HSH housing and related services
- We will share information with relevant Partner agencies if you access many of the HSH's Homelessness Response System (HRS) services.

A list of HSH's Partner agencies with access to the ONE System can be found at: hsh.sfgov.org
<https://hsh.sfgov.org/wp-content/uploads/2020/09/HSH-Partner-Agencies-w-ONE-System-Access.pdf>

Access to information about you is limited by federal, state, and local laws and anyone who can access the ONE system or information about you must sign an agreement that they will follow privacy laws (which are detailed in the attached Notice of Privacy Practices).



By signing this form:

I authorize HSH and its Partner agencies to use and share information collected about me including length of time homeless and information about my vulnerabilities, such as health information, to assess and coordinate services I may be eligible for including: HSH housing and services, benefits, utility assistance, or other related services.

****For San Francisco Health Plan and Anthem Blue Cross Members Only: Authorization to Share My Information with My Health Plan****

The Department of Homelessness and Supportive Housing may share my contact information and information regarding my housing status with my health plan, San Francisco Health Plan, for purposes of coordinating my health care. San Francisco Health Plan staff will comply with all Federal and State privacy laws when they need to access my protected health and/or personal identifying information for determining my eligibility for services.

By signing this form, I understand that:

- The Partner agencies and their staff have signed agreements to maintain the security and confidentiality of my information. I have the right to review all applicable confidentiality policies.
- I understand that I may refuse to sign this Authorization however it will limit the services I am able to receive from non-health care providers at HSH.
- Authorizing the release of my information does not guarantee that I will receive services.
- Information may be shared to get me help if I am an immediate danger to myself or others or if there is suspected abuse of a minor or disabled adult.
- I may see or get a copy of the information collected about me (see Notice for more information),
- I have a right to get a copy of this Authorization.
- I may cancel this Authorization at any time, but I must do so in writing and submit it to the following address:
- P.O. Box 427400, San Francisco, CA 94142-7400 If I cancel this Authorization, further information about me will not be collected or shared but it will not take back or remove the information that has already been collected or shared.
- My information is protected by federal, state, and local regulations governing the confidentiality of client records. My information cannot be further shared without my written consent, except as under the law.
- If my record includes a picture, it can be seen by partner agencies. The photograph may be cropped or edited as needed.
- Partner agencies and Bitfocus staff (System Administrator for the ONE system) who use the ONE System to evaluate HSH housing and services have signed agreements that they will follow all privacy laws.



- I understand that medical, HIV/AIDS, mental health, and drug and alcohol records are protected under various federal and state regulations, including California Welfare and Institutions Code Section 5328, Confidentiality of Medical Information Act, California Civil Code Section 56.10 (CMIA), the Health Insurance Portability and Accountability Act, 45 C.F.R., parts 160 and 164 (“HIPAA”), and the Federal Regulations Governing Confidentiality of Drug Abuse Patient Records, 42 C.F.R., Part 2,. (See the Notice of Privacy Rights for more information)
- Unless allowed or required by law, information received by HSH and partner agencies cannot be shared with anyone else without my consent.

Expiration:

This Authorization expires three years from the date of signature, below or
the earlier date noted here: _____ (insert alternative date, if applicable)

Signatures

Printed name of Client (Head of Household/Primary Applicant) or Legal Representative	Signature of Client (Head of Household/Primary Applicant) or Legal Representative	Date
<i>If signed by an authorized person other than the client, indicate relationship:</i>		
<i>For Staff Use Only: If Client/legal representative refuses to sign, Staff to state the reason for refusal and add staff signature:</i>		
Reason for refusal:		
Staff (Printed Name)	Staff (Signature)	Date
Title	Organization	