Stanislaus County HMIS
Client Informed Consent and Release of Information

You are requesting or receiving services from _____ (Agency Name) who is a member agency of the Stanislaus County System of Care Collaborative (StanCSOC), a group of area service providers that is required to maintain a database of client information to measure and report on the impact of services on ending and preventing homelessness. This database is called the Stanislaus County HMIS (Homeless Management Information System). As a potential or actual client of services, we collect the information listed below to more effectively deliver services in Stanislaus County and to maximize the level of federal funding obtained for our county.

In addition to collecting and sharing the specific data listed below the Stanislaus County HMIS is used to generate general reports on homelessness and reports required by the agencies funding the services you are receiving. These reports **DO NOT** have personal identifying information such as names, social security numbers, date of birth, addresses, or phone numbers (Excluding SSVF Programs).

NOTE: Strict controls are in place to protect your information which is only accessible to authorized personnel of member agencies of the collaborative.

I authorize the following information to be entered into the Stanislaus County HMIS and **shared** between StanCSOC partner agencies:

Identifying Information: *Name, Social Security Number, Date of Birth, Gender, Ethnicity & Race, Marital & Family status, Household Relationships, Phone Numbers, and Address.*

I authorize the following information to be entered into the Stanislaus County HMIS but **not shared** between StanCSOC partner agencies and only accessible by this agency, the HMIS System Administrator, and funding agency authorized users (If Applicable)*:

Basic Information: *Whether or not you have a disability, Veteran, General Health, Education, and Employment status*

Housing Information: *Homeless status, Residence Prior to Program Entry, Zip Code of Last Permanent Address*

Financial Information: *Income and Sources including Non-Cash Benefits*

Disabling Condition*: Physical Disability, Developmental Disability, HIV/AIDS, Mental Health, Substance Abuse, Chronic Health Condition*

Other: *Domestic Violence status, Program Entry Date and Program Exit Date, Services Rendered and Destination after Program Exit*

***Only Applicable if Agency is receiving funding for this program through local government.*

I understand that I may cancel this authorization at any time by written request, but the cancellation will not be retroactive (No records in the system will be removed).

I understand that I have the right to view my HMIS record and will have a report prepared within 7 working days from my written request.

I understand that if I refuse consent to share this information I cannot be denied services unless I am being enrolled in an SSVF program.

This release expires 18 months from the date signed below.

_____	_____	_____
Signature of Client	**Printed Name of Client**	**Date**