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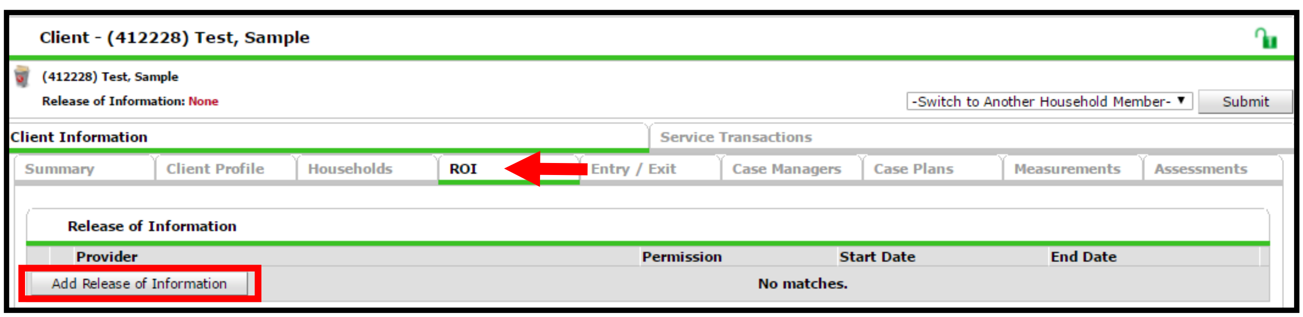
Please Note: This guide is NOT for the Skilled Assessors Project. Skilled Assessors will follow a different procedure for documenting the client's level of consent.

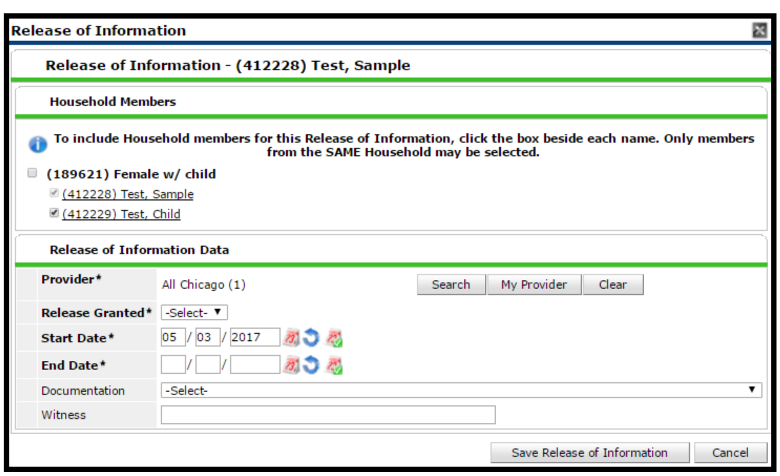
Documenting Release of Information (ROI)

We will be creating up to **three separate ROIs** in HMIS to document the client's data sharing preferences.

1. Consent for Data Sharing (A, B, C or D)
2. Part III Consent to share data with other CoCs in IL
3. Supplemental Disability Consent

Begin from the **ROI** tab and select **Add Release of Information**.





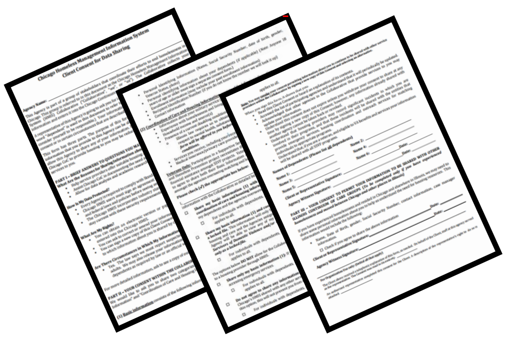
This window will appear.

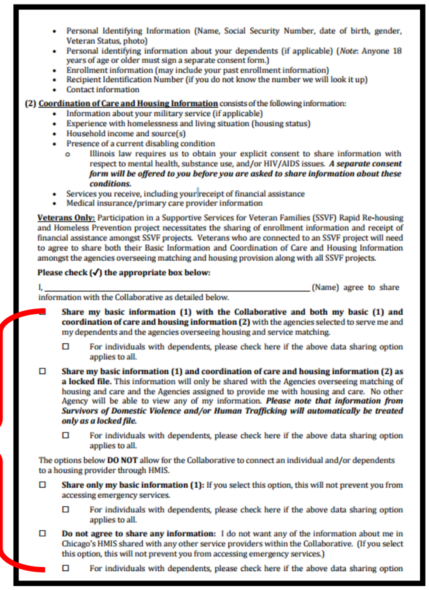
Select the appropriate household members for each ROI.

The **Provider** field should automatically list your agency.

Adding Consent for Data Sharing

The three page *Client Consent* form has four options for data sharing. All four options are located on the lower portion of page 2.





- Personal Identifying Information (Name, Social Security Number, date of birth, gender, Veteran Status, photo)
- Personal identifying information about your dependents (if applicable) (*Note*: Anyone 18 years of age or older must sign a separate consent form.)
- Enrollment information (may include your past enrollment information)
- Recipient Identification Number (if you do not know the number we will look it up)
- Contact information

(2) Coordination of Care and Housing Information consists of the following information:

- Information about your military service (if applicable)
- Experience with homelessness and living situation (housing status)
- Household income and source(s)
- Presence of a current disabling condition
  - Illinois law requires us to obtain your explicit consent to share information with respect to mental health, substance use, and/or HIV/AIDS issues. ***A separate consent form will be offered to you before you are asked to share information about these conditions.***
- Services you receive, including your receipt of financial assistance
- Medical insurance/primary care provider information

Veterans Only: Participation in a Supportive Services for Veteran Families (SSVF) Rapid Re-housing and Homeless Prevention project necessitates the sharing of enrollment information and receipt of financial assistance amongst SSVF projects. Veterans who are connected to an SSVF project will need to agree to share both their Basic Information and Coordination of Care and Housing Information amongst the agencies overseeing matching and housing provision along with all SSVF projects.

Please check (✓) the appropriate box below:

I, ______________________ (Name) agree to share information with the Collaborative as detailed below.

☐ **Share my basic information (1) with the Collaborative and both my basic (1) and coordination of care and housing information (2)** with the agencies selected to serve me and my dependents and the agencies overseeing housing and service matching.

  ☐ For individuals with dependents, please check here if the above data sharing option applies to all.

☐ **Share my basic information (1) and coordination of care and housing information (2) as a locked file.** This information will only be shared with the Agencies overseeing matching of housing and care and the Agencies assigned to provide me with housing and care. No other Agency will be able to view any of my information. ***Please note that information from Survivors of Domestic Violence and/or Human Trafficking will automatically be treated only as a locked file.***

  ☐ For individuals with dependents, please check here if the above data sharing option applies to all.

The options below **DO NOT** allow for the Collaborative to connect an individual and/or dependents to a housing provider through HMIS.

☐ **Share only my basic information (1):** If you select this option, this will not prevent you from accessing emergency services.

  ☐ For individuals with dependents, please check here if the above data sharing option applies to all.

☐ **Do not agree to share any information:** I do not want any of the information about me in Chicago's HMIS shared with any other service providers within the Collaborative. (If you select this option, this will not prevent you from accessing emergency services.)

  ☐ For individuals with dependents, please check here if the above data sharing option

Release of Information Data

Provider*	All Chicago (1)
Release Granted*	Yes
Start Date*	05 / 03 / 2017
End Date*	05 / 03 / 2020
Documentation	A - Share 1 with Collaborative and 1 and 2 with agencies overseeing housing and service matching
Witness	Sal Munoz

Save Release of Information | Cancel

In HMIS, these four options are listed in the **Documentation** field:

A. Share 1 with Collaborative and 1 and 2 with agencies overseeing housing and service matching
B. Share 1 and 2 as a locked file (Data only shared with agencies overseeing matching and housing)
C. Share only 1—Basic information only
D. Does not agree to share any information (Data not shared with any agencies)

Release granted is "Yes" (A, B, C)

Release granted is "No" (D)

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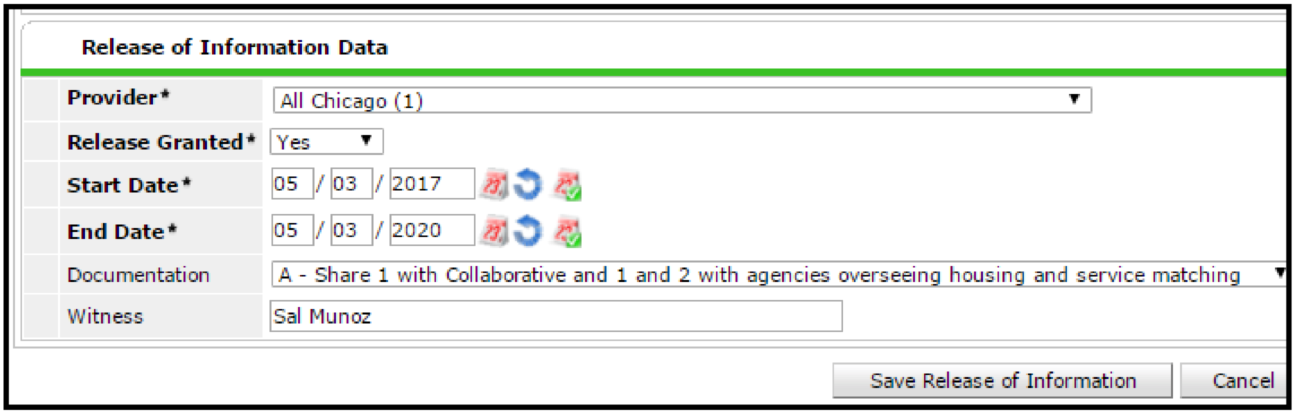
Adding Consent for Data Sharing (cont.)



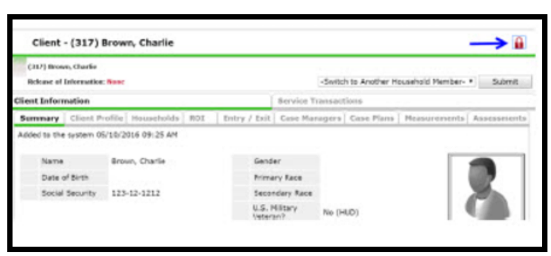
The **Start Date** is the day the client signs the form.

Though the consent form does not have an expiration date, an **End Date** is required. Simply take the start date and add three years.

The **Witness** will be whomever signed the witness section on the form.

Once all fields are filled, click **Save Release of Information**.

NOTE: If the client selects **options B or D**, then you are required to lock that client's file. Directions on how to do so are found here: hmis.thechicagoalliance.org/hc/en-us/articles/209332386-How-to-Lock-a-Client-Record



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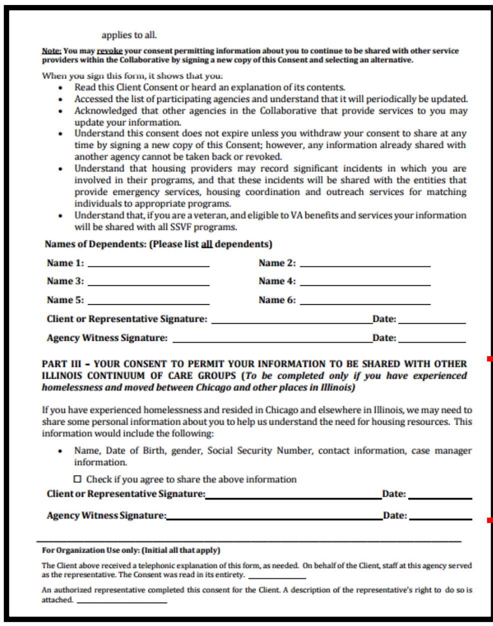
Documenting Client Permission to Share with Other CoCs

To document your client's permission to share their information with other CoCs, another ROI must be created.



applies to all.

Note: You may revoke your consent permitting information about you to continue to be shared with other service providers within the Collaborative by signing a new copy of this Consent and selecting an alternative.

When you sign this form, it shows that you:

- Read this Client Consent or heard an explanation of its contents.
- Accessed the list of participating agencies and understand that it will periodically be updated.
- Acknowledged that other agencies in the Collaborative that provide services to you may update your information.
- Understand this consent does not expire unless you withdraw your consent to share at any time by signing a new copy of this Consent; however, any information already shared with another agency cannot be taken back or revoked.
- Understand that housing providers may record significant incidents in which you are involved in their programs, and that these incidents will be shared with the entities that provide emergency services, housing coordination and outreach services for matching individuals to appropriate programs.
- Understand that, if you are a veteran, and eligible to VA benefits and services your information will be shared with all SSVF programs.

Names of Dependents: (Please list all dependents)

Name 1: __________ **Name 2:** __________

Name 3: __________ **Name 4:** __________

Name 5: __________ **Name 6:** __________

Client or Representative Signature: __________ **Date:** ______

Agency Witness Signature: __________ **Date:** ______

PART III – YOUR CONSENT TO PERMIT YOUR INFORMATION TO BE SHARED WITH OTHER ILLINOIS CONTINUUM OF CARE GROUPS (*To be completed only if you have experienced homelessness and moved between Chicago and other places in Illinois)*

If you have experienced homelessness and resided in Chicago and elsewhere in Illinois, we may need to share some personal information about you to help us understand the need for housing resources. This information would include the following:

- Name, Date of Birth, gender, Social Security Number, contact information, case manager information.

☐ Check if you agree to share the above information

Client or Representative Signature: __________ **Date:** ______

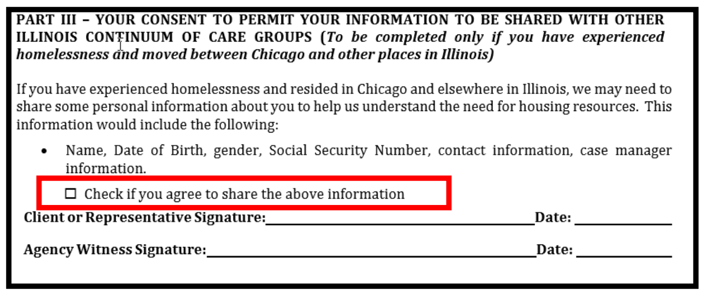
Agency Witness Signature: __________ **Date:** ______

For Organization Use only: (Initial all that apply)

The Client above received a telephonic explanation of this form, as needed. On behalf of the Client, staff at this agency served as the representative. The Consent was read in its entirety. ______

An authorized representative completed this consent for the Client. A description of the representative's right to do so is attached. ______

The information you will need to document is the check box on page 3 of the *Client Consent* form.



PART III – YOUR CONSENT TO PERMIT YOUR INFORMATION TO BE SHARED WITH OTHER ILLINOIS CONTINUUM OF CARE GROUPS (*To be completed only if you have experienced homelessness and moved between Chicago and other places in Illinois)*

If you have experienced homelessness and resided in Chicago and elsewhere in Illinois, we may need to share some personal information about you to help us understand the need for housing resources. This information would include the following:

- Name, Date of Birth, gender, Social Security Number, contact information, case manager information.

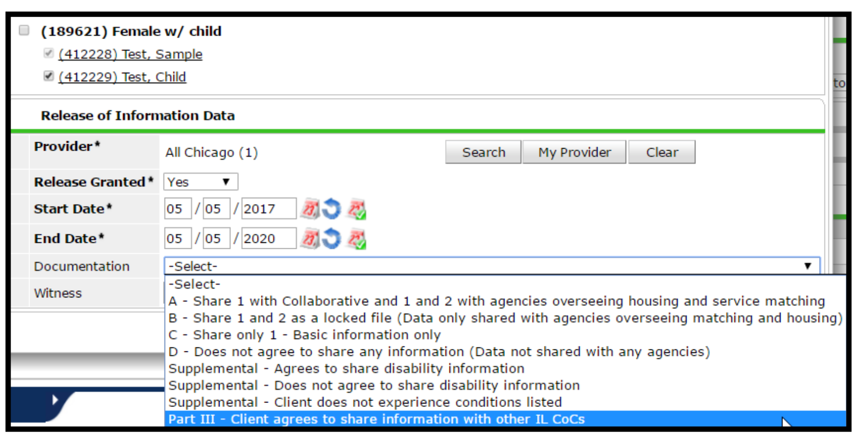
☐ Check if you agree to share the above information

Client or Representative Signature: __________ **Date:** ______

Agency Witness Signature: __________ **Date:** ______

You only need to document the client's release in HMIS if they wished to share their information with other Illinois CoCs (by checking the box and signing). If they have, **Release Granted** will be "Yes".

In the **Documentation** field, go through the same steps to create an ROI and select— "**Part III—Client agrees to share information with other IL CoCs**"

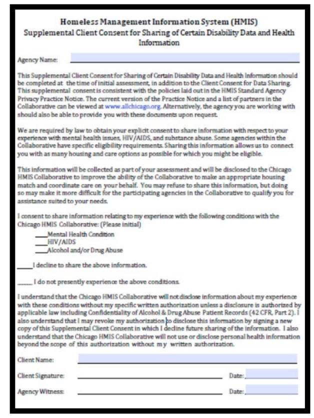


The **Witness** will be whatever staff person signed the form alongside the client.

Click **Save Release of Information**.

Adding the Supplemental Client Consent

To document the one page *Supplemental Client Consent for Sharing of Certain Disability Data and Health Information*, you must create a new ROI.



Homeless Management Information System (HMIS)
Supplemental Client Consent for Sharing of Certain Disability Data and Health Information

Agency Name: ____________

This Supplemental Client Consent for Sharing of Certain Disability Data and Health Information should be completed at the time of initial assessment, in addition to the Client Consent for Data Sharing. This supplemental consent is consistent with the policies laid out in the HMIS Standard Agency Privacy Practice Notice. The current version of the Practice Notice and a list of partners in the Collaborative can be viewed at www.allchicago.org. Alternatively, the agency you are working with should also be able to provide you with these documents upon request.

We are required by law to obtain your explicit consent to share information with respect to your experience with mental health issues, HIV/AIDS, and substance abuse. Some agencies within the Collaborative have specific eligibility requirements. Sharing this information allows us to connect you with as many housing and care options as possible for which you might be eligible.

This information will be collected as part of your assessment and will be disclosed to the Chicago HMIS Collaborative to improve the ability of the Collaborative to make an appropriate housing match and coordinate care on your behalf. You may refuse to share this information, but doing so may make it more difficult for the participating agencies in the Collaborative to qualify you for assistance suited to your needs.

I consent to share information relating to my experience with the following conditions with the Chicago HMIS Collaborative: (Please initial)

____Mental Health Condition
____HIV/AIDS
____Alcohol and/or Drug Abuse

_____I decline to share the above information.

_____ I do not presently experience the above conditions.

I understand that the Chicago HMIS Collaborative will not disclose information about my experience with these conditions without my specific written authorization unless a disclosure is authorized by applicable law including Confidentiality of Alcohol & Drug Abuse Patient Records (42 CFR, Part 2). I also understand that I may revoke my authorization to disclose this information by signing a new copy of this Supplemental Client Consent in which I decline future sharing of the information. I also understand that the Chicago HMIS Collaborative will not use or disclose personal health information beyond the scope of this authorization without my written authorization.

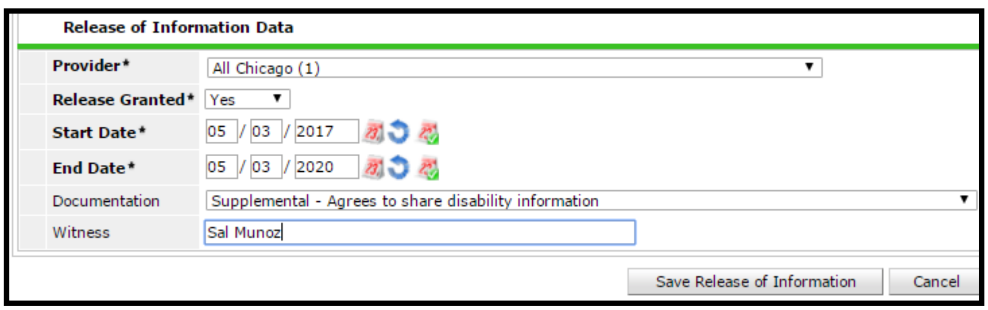
Client Name: ____________

Client Signature: ____________ Date: ______

Agency Witness: ____________ Date: ______

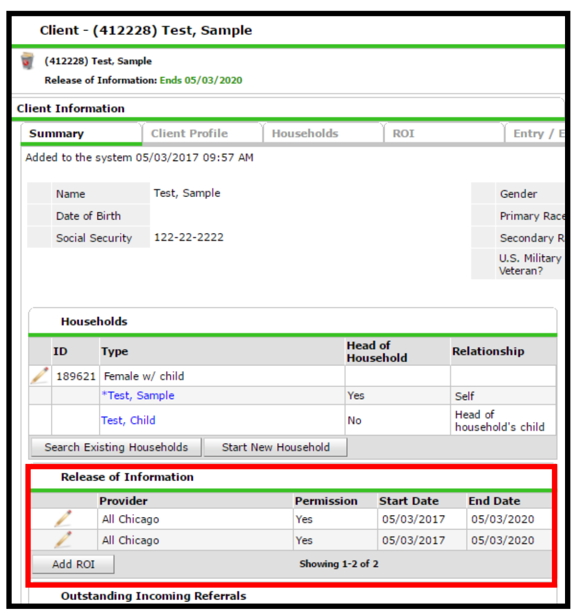
The *Supplemental Client Consent* form has three options for sharing. The below appear in **Documentation** field:

- Supplemental— Agrees to share disability information → **Release granted** is "Yes"
- Supplemental— Does not agree to share disability information → **Release granted** is "No"
- Supplemental— Client does not experience conditions listed → **Release granted** is "Yes"



Save the Release.

Once you save the ROI, your client's summary page should have two ROIs listed in the Release of Information section.



Question? Email the HelpDesk at HMIS@allchicago.org!