HMIS OF SUMMIT COUNTY
A Continuum of Care Program
Administered by Info Line, Inc.

CLIENT INFORMED CONSENT
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

CLIENT NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH

I hereby authorize HMIS of Summit County/UWSM to disclose all of the following information:
(Sign your initials next to information you DO NOT wish to be shared).

_____ Name	_____ Veteran Status	_____ Income History
_____ Race/Ethnicity	_____ Family Status	_____ Employment Skills
_____ Disability Status	_____ Legal History	_____ Admission/Intake History
_____ Educational History	_____ Services Provided History	_____
_____ Progress Notes	_____ Household Relationships	_____

I understand that such information is or may be protected under federal and/or state law, including, but not limited to Protected Health Information, medical records as well as references to substance abuse or psychiatric/mental health treatment which are protected by federal confidentiality rules (42 CFR Part 2 and 45 CFR Parts 160 and 164) and that such information shall be released to:

ACCESS, Inc
Akron AIDS Collaborative
Akron Metropolitan Housing Authority
Battered Women's Shelter of Summit & Medina Counties
Community AIDS Network
Community Health Center
Community Support Services
Family & Community Services
Family Promise
Gus Johnson Community Foundation Inc.
Haven of Rest Ministries
Harmony House
H.M. Life Opportunity Services
Legacy III, Inc.
North Coast Community Homes (NCCH)
Ohio Multi-County Dev. Corp. (OMCDC)
Project RISE (APS)
Shelter Care
Summit County Continuum of Care Direct Services
Tarry House
United Way of Summit & Medina (UWSM)
VA Community Resource Referral Center

I understand that information shall be released to permit appropriate care to be rendered to me.
I further understand that the specific information to be disclosed may include diagnoses, prognoses, and treatment records for treatment of physical and/or mental illnesses and conditions:

- I may revoke this consent at any time, but that there may have been information shared and services provided based upon this Consent when it was in effect. Ending this Consent cannot change that;
- Any notice by me to end this Consent must be in writing;
- This Consent will automatically expire 1 year from the date I sign this Consent;
- The entities specified above are released from any legal responsibility or liability for disclosure of the information described above and as authorized by my signature below; and
- Information may be disclosed to other agencies to assist in obtaining requested services.
- I have the right to inspect or copy any of the information disclosed as a result of this Consent.
- A copy or facsimile (FAX) of this Consent may be utilized in place of the original signed Consent.
- I have received a copy of this Consent.

This Consent has been explained to me. I have read it (or it was read to me) and understand its provisions. I have been given a reasonable amount of time to ask questions and consider whether to permit the sharing of the designated information. I hereby willingly agree to the sharing of that described information.

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____