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/Info Line, Inc. 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 | Info Line, Inc. |
| Akron Metropolitan Housing Authority | H.M. Life Opportunity Services |
| Community AIDS Network | Legacy III, Inc. |
| Community Health Center | Ohio Multi-County Dev. Corp. (OMCDC) |
| Community Support Services | Oriana House |
| Department of Job & Family Services | Shelter Care |
| Fair Housing Contact Service | Springtime of Hope |
| Family & Community Services | Summit County Children Services |
| Family Promise | Tarry House |
| Haven of Rest Ministries | The Salvation Army |

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: _____