



**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 may include 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 | Interfaith Hospitality Network |
| Community AIDS Network | Legacy III, Inc. |
| Community Support Services | Ohio Multi-County Dev. Corp. (OMCDC) |
| Department of Job & Family Services | Oriana House |
| Fair Housing Services | Shelter Care |
| Haven of Rest Ministries | Springtime of Hope |
| H.M. Life Opportunity Services | Tarry House |
| Info Line, Inc. | The Salvation Army |

I understand that information shall be released to permit appropriate care to be rendered to me.

I also understand that:

- 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: _____