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

I understand that such information may include Protected Health Information 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 Part 164) and that such information shall be released to:

H.M. Life Opportunity Services, Summit County Department of Job & Family Services, The Salvation Army, Summit County Children's Services, Fair Housing Contact Service, Info Line, Inc., and Community Legal Aid

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
- I have the right to inspect or copy any of the information disclosed as a result of this Consent.

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____