SANTA CLARA COUNTY HMIS
CLIENT CONSENT TO DATA COLLECTION AND RELEASE OF INFORMATION

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Santa Clara County Homeless Management Information System ("SCC HMIS") is a shared database and software application which confidentially collects, uses, and shares client-level information related to homelessness in Santa Clara County. On behalf of the Santa Clara County Continuum of Care ("CoC"), SCC HMIS is administered by the County of Santa Clara ("County") and Bitfocus, Inc. ("Bitfocus") in a software application called Clarity Human Services ("Clarity"). Clients must consent to the collection, use, and release of their information, which helps the CoC to provide quality housing and services to homeless and low-income people.

Client information is collected in SCC HMIS and released to housing and services providers (each, a "Partner Agency," and collectively, the "Partner Agencies"), which includes community based organizations and government agencies. Partner Agencies use the information in SCC HMIS: to improve housing and services quality; to identify patterns and monitor trends over time; to conduct needs assessments and prioritize services for certain homeless and low-income subpopulations; to enhance inter-agency coordination; and to monitor and report on the delivery, impact, and quality of housing and services.

Client information is protected by limiting access rights to the database and by limiting the parties to whom the confidential information may be released, in compliance with federal, state, and local regulations governing the confidentiality of client records. Each person or agency with access rights to SCC HMIS, or to whom client information is released, must sign an agreement to maintain the security and confidentiality of client information. Upon any violation of the agreement, access rights may be terminated, and the person or agency found to be in violation of the agreement may be subject to further penalties.

BY SIGNING THIS FORM, I AUTHORIZE THE FOLLOWING:

- **I authorize the County, Bitfocus, the CoC, the Partner Agencies, and their authorized agents and representatives to collect, use, and share basic information about me**. I understand that the Partner Agencies may change over time, and that a current list of Partner Agencies has been provided to me. I also understand that I may request an

updated list at any time or view the list at: http://scc.hmis.cc/partner-agencies.html. I understand that the collection, use, and release of this information is for the purpose of assessing my needs for housing, counseling, food, utility assistance, or other services.

- By initialing one or more of the space(s) in the table below, I authorize that the information or records entered into SCC HMIS may include the following specific types of protected personal information ("PPI") and protected health information ("PHI"). If I do not initial one or more space(s) in the table below, I do not authorize the specific type of information to be entered into SCC HMIS:

Client initials	Type of PPI/PHI
	• Identifying information (including: name, birth date, gender, race, ethnicity, social security number, phone number, residence address, or other similar identifying information)
	• My photograph or other likeness
	• Medical information included in my responses to questions asked as part of the standard HMIS intake and identification as a client or patient of the Santa Clara Valley Health and Hospital System
	• HIV/AIDS-related information included in my responses to questions asked as part of the standard HMIS intake
	• Mental health information included in my responses to questions asked as part of the standard HMIS intake and identification as a client receiving mental health services from the County's Behavioral Health Services Department
	• Substance abuse treatment information included in my responses to questions asked as part of the standard HMIS intake and identification as a client receiving substance abuse or alcohol treatment from the County's Behavioral Health Services Department
	• Financial and benefits information (including: employment status, income verification, public assistance payments or allowances, food stamp allotments, health care coverage, or other similar financial or benefits information)
	• Housing information
	• Information about services provided by HMIS Partner Agencies (including: date, duration, and type of service; and other similar service information)
	• Other (specify): _____ _____

- I authorize Partner Agencies and their authorized agents and representatives to use the PPI and PHI collected in SCC HMIS to prioritize me for and refer me to housing and services. I further authorize the Partner Agencies and their authorized agents and representatives to communicate with other Partner Agencies and their authorized agents and representatives about my case for the purposes of coordinating prioritization and placement and determining eligibility for housing and services.

BY SIGNING THIS FORM, I UNDERSTAND THAT:

- **This Consent will expire on [insert date] _____.** This consent is not valid if an expiration date is not included.

- Use of my likeness in a photograph will be viewable by the Partner Agencies and their authorized agents and representatives. The photograph may be cropped or edited as needed.

- The Partner Agencies and their authorized agents and representatives individually have signed agreements to maintain the security and confidentiality of my information. I have the right to review all applicable confidentiality policies and signed agreements.

- **I understand that I may refuse to sign this Consent.** My refusal will not affect my eligibility for benefits or services, or my ability to obtain treatment or payment. In addition, consenting to the release of my information does not guarantee that I will receive services, and my refusal to consent does not disqualify me from receiving services. I have a right to receive a copy of this authorization.

- I may revoke this Consent at any time, but I must do so in writing and submit it to the following address. This Consent may be revoked verbally for records relating to drug/alcohol treatment or mental health treatment.

  Bitfocus, Inc.
  ATTN: SCC HMIS
  548 Market St #60866
  San Francisco, CA 94104

- If I revoke this Consent, the revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Consent.

- My PPI and PHI are protected by federal, state, and local regulations governing the confidentiality of client records. My information cannot be released without my written consent, except to the extent that the regulations provide otherwise.

- Auditors or funders who have legal rights to monitor or review the work of one or more Partner Agencies, including the U.S. Department of Housing and Urban Development, may view my PPI in the ordinary course of their work.

- Bitfocus serves as the System Administrator for SCC HMIS and software vendor of Clarity. To the extent that authorized agents and representatives of Bitfocus perform work on SCC HMIS, they may view my information in the ordinary course of their work.

- Partner Agencies and their authorized agents and representatives who use SCC HMIS to research and write reports have signed agreements to maintain the security and confidentiality of client information.

- I understand that medical, HIV/AIDS, mental health, and drug and alcohol records are protected under various federal and state regulations, including California Welfare and Institutions Code Section 5328, Confidentiality of Medical Information Act, California Civil Code Section 56.10 (CMIA), the Health Insurance Portability and Accountability Act, 45 C.F.R., parts 160 and 164 ("HIPAA"), and the Federal Regulations Governing Confidentiality of Drug Abuse Patient Records, 42 C.F.R., Part 2, and cannot be disclosed without my written consent unless otherwise permitted by law.

- I expressly authorize my information disclosed pursuant to this Consent to be further disclosed by the recipients listed above for the purposes of assessing my needs for housing, counseling, food, utility assistance, or other services as part of the work of the CoC and HMIS .

[Signatures on the following page]

SIGNATURE

Date: _____ Time: _____ AM/PM

Signature of Patient/Client or Representative:

_____

If signed by a person other than the patient/client, indicate relationship:

_____

Print Name:

_____

THE FOLLOWING IS REQUIRED ONLY FOR RELEASE OF INFORMATION FOR CLIENTS RECEIVING MENTAL HEALTH SERVICES FROM THE COUNTY'S BEHAVIORAL HEALTH SERVICES DEPARTMENT, OR AS OTHERWISE OUTLINED IN CALIFORNIA WELFARE AND INSTITUTIONS CODE SECTION 5328:

☐ I authorize the release of the requested information.

☐ I do not authorize the release of the requested information.

Signature of Authorized Mental Health Staff:

_____

Name/Title:

_____