

# TREASURE COAST HOMELESS SERVICES COUNCIL, INC.

## CLIENT CONSENT FOR DATA COLLECTION

Participation in data collection is a required component of the community's ability to provide the most effective services and housing possible. Please understand that access to shelter and housing services is available without participation in data collection.

This client notice and consent describes how information about you may be used and disclosed and how you get access to this information. Please review it carefully. If you have any questions or desire any further information regarding this form Please contact \_\_\_\_\_ at \_\_\_\_\_

I, \_\_\_\_\_ understand and acknowledge that \_\_\_\_\_ is affiliated with the HMIS, and I consent to and authorize the collection of information and preparation of records pertaining to the services provided to me by the agency. The information gathered and prepared by the agency will be included in a Homeless Management Information System (HMIS) database and shall be used by the agency to:

- A.) Provide individual case management
- B.) Produce aggregate-level reports regarding use of services
- C.) Track individual program –level outcomes
- D.) Identify unfilled service needs and plan for the provision of new services
- E.) Allocate resources among agencies engaged in the provision of services

Please initial the following appropriate information:

\_\_\_\_\_ I understand and acknowledge the following collection of information

\_\_\_\_\_ Identifying information (Name, birth date, gender, race, social security number, residential information, phone number, family information)

\_\_\_\_\_ Medical records (except HIV/AIDS and alcohol/ drug treatment), Psychological records and evaluations, vocational assessment, care coordinators recommendations and direct observation, employment status, etc.

\_\_\_\_\_ Financial information (income verification, public assistance payments and allowances, food stamp allotments)

\_\_\_\_\_ HIV/AIDS diagnosis

\_\_\_\_\_ Substance abuse diagnosis, treatment plan, progress in treatment, discharge.

\_\_\_\_\_ For specific purpose of: \_\_\_\_\_ further care \_\_\_\_\_ evaluation \_\_\_\_\_ other-

Please specify other \_\_\_\_\_.

\_\_\_\_\_ I understand that I have the right to inspect, copy and request all records maintained by the Agency relating to the provision of services to me and to receive a paper copy of this form.

\_\_\_\_\_ I understand that this release can be revoked by me at any time and that the revocation must be signed and dated by me. I further understand that this consent is subject to revocation at any time, except to the extent that the Agency has already taken action in reliance on it. If not previously revoked, this consent terminates automatically ONE year after my last treatment or discharge from the Agency.

\_\_\_\_\_ I understand that my records are protected by Federal, State and local regulations governing confidentiality of client records and cannot be disclosed without my written consent unless otherwise provided for in regulations.

\_\_\_\_\_ Additionally, I understand that participation in data collection is optional and may be able to access other shelter and housing options not available under this grant if I choose not to participate.

\_\_\_\_\_  
Head of Household Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Spouse/ Significant other

\_\_\_\_\_  
Date