Coordinated Access for Adults and Families: Authorization for Disclosure of Confidential Information

Please note: Cross Sector Case Conferencing requires written authorization in order to proceed.

Coordinated Access for Adults and Families is a network of separate agencies that coordinate the delivery of rental assistance and supportive services to individuals and families, primarily who are homeless, with priority for those with the longest history of homelessness and most service needs. A full list of Coordinated Access for Adults and Families partner agencies is available upon request and published online at johs.us/coordinated-access/coordinated-access-2/.

Coordinated Access for Adults and Families agencies will enter the information you provide into a vendor-hosted Homeless Management Information System (HMIS), a computerized and secured record-keeping system known as ServicePoint. These agencies are required by law to maintain the privacy of your personal information. Your information will not be disclosed to other agencies without your authorization except as required or permitted by law. Coordinated Access for Adults and Families is a collaborative effort that provides a centralized approach to assessing and prioritizing individuals and families experiencing homelessness for housing, social, and health services. Coordinated Access for Adults and Families collects personal information from individuals, including income, employment, disability status, veteran status, history of homelessness, current housing situation, and service needs. This information is used to assess eligibility for housing, social, and health services, prioritize need, refer to providers, track progress, and evaluate the system's effectiveness. The Coordinated Access for Adults and Families system may share personal information with housing, social and health service providers, government agencies, researchers, and other organizations working to end homelessness and erase health disparities. Individuals have the right to access, correct, delete, and opt-out of sharing their personal information with researchers. For more information, contact the Coordinated Access for Adults and Families system at the provided contact information.

By signing this form, I authorize the entities listed on Attachment A to disclose: my Client Record [Name, Social Security Number, and Veteran Status], Demographics [Date of Birth, Gender, Race, and Ethnicity], healthcare information [health plan enrollment, current and past providers, current and historic conditions and treatment], Coordinated Access related Program Enrollment and Exit Information, information about the nature of my situation, and Services and Referrals I receive, to Coordinated Access for Adults and Families partner agencies for the purpose of payment, health care operations activities and coordination of housing, healthcare, disability, and services addressing social determinants of health. I also authorize the disclosure of information to Housing Owners or Property Managers to facilitate access to housing opportunities.

Additionally, I authorize the disclosure of information between multiple Multnomah County agencies and external providers (See Attachment A) for the purpose of coordinating care and interventions that will help to improve my health and wellness and aid in my access to and retention of housing.

If you have questions about your privacy, please contact the Coordinated Housing Access Team (CHAT) Hotline at 844-765-9384.

I authorize the disclosure of the following categories of personal information
A. Mental Health Initial/s: _____ Initial/s: _____

Authorizations regarding Substance Use Disorder Services are covered by 42CFRpt2, and will require separate authorization. Please ensure this separate authorization is signed if such services will be discussed during Case Conferencing.

I understand that this information may include information that would otherwise be protected by Oregon and federal law. All Coordinated Access for Adults and Families participating agencies acknowledge that any information disclosed among these agencies will not be re-disclosed to other parties without my further written authorization, unless otherwise required or permitted by law.

This authorization becomes effective on the date below and will expire 12 months from my last date of participation in Coordinated Access for Adults and Families; a period reasonably needed to complete the disclosure of information for the purposes described and named in this authorization unless I indicate otherwise. Specific expiration date: _____.

I may revoke this authorization at any time except to the extent that action has already been taken in reliance on it. Revocation of this authorization is effective upon receipt by a Coordinated Access for Adults and Families agency.

This authorization is voluntary. I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits related to housing and services outside of Cross Sector Case Conferencing. Refusing to sign this authorization may affect my engagement with Cross Sector Case Conferencing and Referrals.. I may inspect or copy any information used and/or disclosed under this authorization. My signature below indicates I approve of this authorization and understand its meaning.

ATTACHMENT A

CORE PARTNERS

The Joint Office of Homeless Services works in partnership with the following agencies who are

NOT HMIS participating agencies as part of the Coordinated Access for Adults and Agencies continuum. For case conferencing and care coordination purposes, limited Personal Identifiable Information (PII) and Protected Health Information (PHI) provided may be shared with these partners. The current list of Partner Agencies who are NOT HMIS participating agencies may change over time. I authorize my personal information to be disclosed with any new HMIS Partner Agency.

1. Oregon Health Authority's Oregon Health Plan

- Health Share of Oregon and Trillium
    - Coordinated Care Organizations
        - and their contracted providers

2. Multnomah County

- Health Department
- Department of County Human Services
- Department of Community Justice

3. Community Solutions

Please list the names and dates of birth of all household members participating in services:

_____ _____

_____ _____

_____ _____ _____

Client or Legal Guardian Name (please print) Client or Legal Guardian Signature Date

_____ _____ _____

Additional Adult's Name (please print) Additional Adult Signature Date

ONLY COMPLETE THIS SECTION TO REVOKE PREVIOUS AUTHORIZATION

I revoke this authorization. Signature: _____ Date: _____

Signature: _____ Date: _____