Suncoast Continuum of Care

RELEASE OF INFORMATION

Authorization to Use or Disclose Personal Information including Protected Health Information (PHI)

Name:	Social Security Number:	Date of Birth:
Name of Provider Agency:		

I authorize the use or disclosure of personal information, including protected health information, about the individual named above.

I am: ☐ the individual named above
☐ a personal representative because the person is a minor, incapacitated, or deceased

_____ participates in the Sarasota/Manatee Continuum of Care (FL-500) coordinated entry system (Oneby1) and/or the Community Services Information System (CSIS). These systems include organizations that provide homeless and housing assistance and supportive services. As part of CSIS and the Oneby1 system, agencies agree to share information about individuals and families with other agencies in order to coordinate services and help a household find and/or keep housing as quickly as possible.

The information to be disclosed may include personal information contained within the Community Services Information System, records from providers detailing my medical conditions and including information on disabilities, mental health, drug abuse, alcoholism, sickle cell anemia, human immunodeficiency virus (HIV) infection, AIDS, and other communicable disease test results and diagnoses. Information contained within the Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-SPDAT), the Service Prioritization Decision Assistance Tool (SPDAT), other assessment forms, and other information collected as part of case management, case planning and case conferencing will be shared in CSIS and as it relates to the coordination of services for housing placement and stability.

Important Rights and Other Required Statements You Should Know

You can revoke this authorization at any time by writing to the Suncoast Partnership to End Homelessness, Inc., 1750 17th Street / C-1, Sarasota, FL 34234. If you revoke this authorization, it will not apply to information that has already been used or disclosed.

You have a right to a copy of this authorization once you have signed it. Please keep a copy for your records, or you may ask us for a copy at any time by writing to Suncoast Partnership to End Homelessness, Inc. 1750 17th Street / C-1 Sarasota, Florida 34234.

If you have any questions about anything on this form, or how to fill it out, we can help. Please call the Suncoast Partnership at 941-955-8987.

This authorization will expire two (2) years from the date this document was signed by the individual or personal representative below.

By signing this authorization, I am attesting that I understand: ***(Initial each line)***

_____The reason I am being asked to release information.

_____My protected health information, including, but not limited to, mental health, drug & alcohol, HIV/AIDS information can be shared with partner providers and CSIS participating organizations. I understand that agencies participating may change from time to time and that a copy of the current list of agencies is available upon request from the Suncoast Partnership by calling 941-955-8987.

_____The CSIS operates over the internet and uses many security protections to ensure the complete confidentiality of my records.

_____Signing this authorization is voluntary, and I do not have to agree to authorize any use or disclosure. I understand that the ability to receive services or support is not conditioned upon authorizing this disclosure. However, by not giving authorization to share information, I may not be able to access housing help as quickly as possible and that some services that result from a coordination of activities between providers may be limited in availability. Some agencies require certain questions to be answered in order to determine eligibility for their projects.*

_____The providers that have access to my protected health information are prohibited from re-disclosing information outside of the terms of his release of information form, without my written authorization except as permitted by federal or state law.

Signature _____ Date (required) _____

Dependent(s) that the Legal Guardian Authorizes to Participate in the SMCSIS:

Name_____ DOB___/___/___ Name_____ DOB___/___/___

Name_____ DOB___/___/___ Name_____ DOB___/___/___

Name_____ DOB___/___/___ Name_____ DOB___/___/___

Signature of Personal Representative (if applicable)

Signature _____ Date (required) _____

Please describe your relationship to the individual and/or your legal authority to act on behalf of the individual in making decisions related to healthcare and services. You may be asked to provide us with the relevant legal document giving you this authority.

Relationship to the individual (required): _____

Signature of Witness

Signature _____ Date (required) _____

*Agencies may have additional requirements that must be agreed upon by the participant. If applicable, these requirements will be listed on page 3.