Vermont HMIS
Client Informed Consent and Release of Information

PERMISSION TO SHARE CONFIDENTIAL INFORMATION TO SECURE NECESSARY SERVICES

Please read the following notice and authorization (or ask to have it read to you) before signing.

This agency _____ participates in the Homeless Management and Information System. Agencies that participate in the Vermont HMIS belong to an internet-based network. This network is administered by the Institute for Community Alliances (ICA). The name of the software vendor that developed and maintains the software is called Bitfocus. The name of the software that stores this data is Clarity Human Services.

Benefits to Data Sharing for the Consumer	
Eliminates Duplicate intakes	Faster access to the Coordinated Entry System, resulting in receiving services more quickly
Reduces the amount of time spent answering basic questions regarding your situation	Allows agencies to focus on meeting your unique service needs
Reduces the amount of times you have to tell your story to service providers	Multiple Services can be easily coordinated and streamlined

Bitfocus ensures the security of its system. Please see below for detailed information on security measures.

Because this network is made up of many service providers, you have the option to share your information with other service providers from whom you might be seeking services. Your identity and information collected in the HMIS will be shared, with your written consent, in the network and with network partners who have written agreements with ICA. HMIS includes your demographic information and other essential personal information needed to best determine your service needs. Each adult in the household can give permission to share only their own personal information. Any guardian may give permission to share a child's information.

The software program used for this purpose has industry standard security protocols and is updated regularly to meet these security requirements. The information you provide will only be shared with this agency, the network, network partners and limited staff of the Institute for Community Alliances. Personally identifying information will not be shared with any State or Federal department for the purposes of determining your eligibility in other State or Federal programs. Information collected is housed in a secure server owned and hosted by Bitfocus in Virginia, Ohio, Oregon, and California. Limited Bitfocus staff have access to this server and the data for the purposes of network support and maintenance. Data collected for the network will be maintained for at least seven years from the last date of service.

The list of agencies participating in the network and network partners can be accessed on the ICA website here, https://icanewengland.helpscoutdocs.com/article/282-vermont-hmis-governance. *This list may change.*

Please note if you grant permission for your information to be shared, that agreement will be in effect until you revoke it in writing. You may end your agreement in writing and your service information will no longer be shared from that date going forward. If you do not give permission for this agency to release your information, no other agency in the network or network partner will have access to it.

Maintaining the privacy and the safety of those using our services is very important. Your record will only be shared if you give permission. You cannot be denied services that you would otherwise qualify for if you choose not to share information. However, even if you choose not to share your information with other agencies, federal and state regulations may require limited data collection for funding purposes.

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TYPE OF INFORMATION TO BE SHARED:

- Personal Identifying Information: Name (First, Middle and Last), Social Security Number, Date of Birth, Gender, Race, Ethnicity, Last Residence Information, Military Status
- Program Specific: Program Enrollments, Assessments, Income*, Non-cash Benefits*, Disability*+, Domestic Violence*, Health Insurance*, Services, Case Notes, Referrals, File Attachments
- All other data that is pertinent for program reporting, eligible and referral purposes

* Self-report for HMIS purposes.

+ Includes if you say Yes or No to Substance Use, Mental Health and/or HIV/AIDS. Diagnosis is not collected. All self-reported for HMIS purposes.

BY SIGNING THIS FORM, I UNDERSTAND:

- The reason I am being asked to release information.
- Signing this authorization is voluntary. 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.
- While our agency will take every precaution to protect my personal and health information, once it is released pursuant to this authorization, it may be subject to re-disclosure by other parties.
- I may revoke this authorization at any time by contacting _____ at _____ except to the extent that it has been acted upon.
- I will be provided with a copy of this form.
- All items on this form have been completed and my questions about this form have been answered.
- I am granting permission to share information for the minor children and adults under my legal guardianship listed below.

Please indicate name, date of birth and last 4 digits of Social Security Number (SSN) for each child that are in the household:

Name	Date of Birth	Last 4 Digits of SSN

Created: February 2024

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PLEASE INDICATE YOUR CHOICE REGARDING DATA SHARING

- **Option 1:**

_____By initialing here, I agree to share my and my child/children's above specified information and coordinate services with all agencies that have agreed to share HMIS data in accordance with the VT HMIS Policy and Procedure Manual.

- **Option 2:**

_____By initialing here, I do NOT agree to share my and my child/children's above specified information and coordinate services with all agencies that have agreed to share HMIS data in accordance with the VT HMIS Policy and Procedure Manual.

I understand that signing below relates only to data sharing within the HMIS and does not guarantee I will receive assistance. Alternatively, I understand that I will NOT be denied services if I refuse to consent to data sharing.

CLIENT

Print Client Name: _____

Client Signature: _____ **Date**: _____

INTERVIEWER

Print Interviewer Name: _____

Interviewer Signature: _____

Position/Job Title: _____

Agency: _____**Date**: _____