

Rhode Island Continuum of Care Authorization to Share Information

The RI Continuum of Care (RI CoC) is comprised of a network of government agencies and non-profit organizations that provide shelter, housing, and other services to individuals and families who are homeless. In order to provide you with the best services possible, it is important that all of the agencies working with you are able to share information in order to plan and coordinate the services that you need. Only authorized staff that perform case management and/or administrative functions, may exchange information about you in written form (on paper) or verbally (through conversations or telephone calls) or electronically (through a shared database). We must have your written permission to share this information. Your signature on this authorization allows homeless service agencies to share your information in order to give you the best services possible. A list of these agencies is available upon request.

I authorize the RI CoC to share the following information about me with member agencies. **All staff members accessing information are trained in confidentiality procedures. All RI CoC network members have signed agreements to treat personal information confidentially.**

The following information A) is available **only to authorized staff** who need to access the shared database in order to identify clients in their projects as well as to case managers and administrators:

A) Personal identifying information, such as my name, date of birth, and social security number.

The following information B) can be shared **only among authorized staff** that perform case management and/or administrative functions:

B) Income and assets, public benefits, health insurance, housing and employment history, educational background, incarceration history, probation status, behavioral health information, mental health treatment history, physical health information, and past use of homeless services and contacts with network members.

Because the network receives funding from the federal government, we must collect the following information C), which will be stored in a database maintained by Bowman Systems Inc. Aggregate information will be included in reports required by the U.S. Department of Housing and Urban Development but **neither you nor your family members will be individually identified in any of these reports.:**

C) Name; birth date, social security number; gender; ethnicity and race; veteran status, disability status, and prior living situation.

I understand that signing this form does not guarantee that I will receive assistance. Refusing to sign this form will not disqualify me from receiving basic services although some programs will have additional eligibility and information sharing requirements that I will need to meet. I understand that I may withdraw this consent at any time by submitting a written request to the program named below. The withdrawal will become effective on the date signed and does not apply to information that has already been disclosed.

This authorization is valid until I withdraw it in writing.

Client name (print): _____ Signature: _____

Witness name (print): _____ Signature: _____

Program/Agency (print): _____ Date: _____