Release of Information

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. IF YOU HAVE ANY QUESTIONS OR DESIRE ANY FURTHER INFORMATION REGARDING THIS FORM, PLEASE CONTACT THE UNITY PROJECT MANAGER AT 813.223.6115.

In order to best serve your needs at _____, to develop meaningful treatment plans, to determine your continuing eligibility for services, and to monitor your progress in complying with the terms of your shelter, housing or other services, Agency and the Continuum of Care need to exchange, share, and/or release data, information or records they may collect about you.

The information contained in your case records with any Agency is considered confidential and privileged and cannot be exchanged, shared and or/released without your express and informed written consent, except where otherwise authorized by law. Please understand that access to shelter, housing and services is available without your consent for the release of the information. However, your consent, although optional, is a critical component of our community's ability to provide the most effective services and housing possible.

I understand that:

- This Agency may not condition the provision of services to me on my signing this consent/authorization (this Agency may not refuse to serve me simply because I do not want my information shared with other agencies).
- This form specifically authorizes the use of information about me in research conducted using information maintained in UNITY Information Network. I will not be personally identified by name, social security number, or any other unique characteristic in published research reports. The type of research that will be conducted using this information includes reports on the number and characteristics of people using different types of services, the effectiveness of services, and changes in patterns over time.
- If I give permission, the UNITY Information Network allows information about me, including my photograph, to be shared with other UNITY Information Network Partner Agencies. This may include, but is not limited to, all of the information collected on the Tampa/Hillsborough CoC Universal Intake, household information, program entry/exit information, case manager and case plan information, information captured in the SSOM (Self Sufficiency Outcome Matrix), service transaction information, homeless verification, information regarding education and employment background, income, program eligibility and participation, any additional profile information and personal history. The purpose of sharing information this way is to help the agencies that I seek services from obtain information about me more quickly, assist with my case management, and to help connect me with the services I need.
- Unless I place restrictions, in writing, on the agencies that may see information about me, all UNITY Partner Agencies will be able to see the information that this Agency puts into UNITY Information Network. Upon my request, this Agency must show me a list of the agencies participating in the UNITY Information Network at the time I sign this consent/authorization.
- Agencies that join UNITY Information Network after I sign this consent/authorization also will have access to the personal information that I authorize for data sharing. This Agency must make reasonable accommodations to allow me to view the updated list of UNITY Partner Agencies so long as my consent remains in effect.
- I understand that I have the right to inspect, copy, and request all records maintained by Agency relating to the provision of services provided by Agency to me and to receive copy of this form. 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 authorized by law.
- I understand that this consent/authorization can be revoked by me at any time in writing by delivering a dated and signed written request to this Agency. I understand that my consent will automatically expire seven (7) years from the date of this form in the event that I do not revoke my consent earlier. However, I understand and acknowledge that regardless of the expiration or revocation of my consent, such as expiration or revocation (as the case may be) shall not apply to any of my data or information that has already been collected.

I have read this document or it was read and/or explained to me and I fully understand and agree with the terms of this document.

_____ _____

PRINT CLIENT NAME CLIENT UNITY ID NUMBER

_____ _____ _____ _____

SIGNATURE OF CLIENT OR GUARDIAN DATE SIGNATURE OF AGENCY WITNESS DATE