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CNYHMIS Client Consent Form

Client Name: ___________________________ Date of Birth:___________________________

Agency: ________________________________Program: ___________________________

I know that this agency is part of the CNY HMIS (Homeless Management information System). The CNY HMIS is a system that uses computers to collect information about homelessness in order to help plan and pay for services to people who are homeless or requiring services to prevent homelessness. The CNY HMIS is administered by the Housing and Homeless Coalition of Central New York (HHCCNY).

With this written consent, CNY HMIS agencies that offer me services may see, and update basic information about me and/or my children including name, gender, race, ethnicity, birth date, veteran status, proof of homelessness, income, insurance, disabilities (including HIV/AIDS status) and service transactions related to housing, food, and material goods.

The Agency shall only release client records to non-partner agencies with proper written consent by the client unless otherwise permitted by relevant laws or regulations. Any research performed with this data is completely de-identified. No personally identifying information will ever be revealed in research or public reporting from HMIS data.

Decisions to deny outreach, shelter, or housing will not be based solely on information in this system. My decision to sign or not sign this consent document will not be used to deny outreach, shelter, or housing services.

I may withdraw the consent except for information that has already been given out or actions already taken, by informing the agency in writing that I want to withdraw my consent. This consent will **end one year** from the date signed.

I have a right to see my CNY HMIS record, ask for changes, and to have a copy of my record from this agency upon written request.

CNY HMIS Agencies Participating, Coordinated Entry agencies in bold:

ACR Health, Altamont (GPD Program), **Catholic Charities**, **Cayuga Community Health Network, Cayuga County DSS**, **Community Action Programs Cayuga/Seneca**, Circare, City of Syracuse, **Chadwick Residence**, **Chapel House Inc**., Contact Community Services, **Dept of Veteran Affairs**, **Helio Health**, Hiscock Legal Aid, Housing & Homeless Coalition of CNY (HHC CNY), Housing Visions, **In My Father's Kitchen**, InterFaith Works, Legal Aid Society of Mid-York, **Liberty Resources**, **Onondaga County DSS**, **Onondaga County Division of Mental Health for Children, Families, and Individuals**, Onondaga County Justice Center/Jamesville Correctional Facility, **Oswego County Opportunities**, **Oswego County DSS**, **Rescue Mission**, **Soldier On**, St Joseph's Care Coordination Network, **The Salvation Army**, Samaritan Center, Syracuse Housing Authority, Syracuse/Onondaga County Youth Bureau, Suny Upstate Medical University**, A Tiny Home for Good**, **Victory Transformations Shelter**, Volunteer Lawyers Project of Onondaga County, Inc., **YMCA of Central NY, YWCA**, and The New York State Office of Temporary and Disability Assistance (OTDA).

Dates of release _______/_______/________ to ________/_________/__________
(Date of first service) (One year from date of first service)

Coordinated Entry Releases

- ☐ I authorize HHCCNY to share my homelessness history as it is recorded in HMIS with___(Agency name)____ and other Coordinated entry Agencies
- ☐ I authorize ____(Agency name)____ and HHCCNY to record and share my medical information pertaining to my eligibility for housing programs. This information is only shared with Coordinated Entry Agencies, and the minimum necessary information is collected and shared.

________________________________ ________________________________
Client Signature Date

________________________________ ________________________________
Agency Witness Date

Only check if you are ***rescinding*** authorization to release information in HMIS.

- ☐ I rescind my authorization to the CNY HMIS. I do not want any future information to be shared with other agencies in the HMIS

________________________________ ________________________________
Client Signature Date

Consent on behalf of household members – An adult head of household may provide consent on behalf of their family members to share their information in the HMIS.

Head of household name : ____

Name ____________________________Date of Birth:________________________

Name ____________________________Date of Birth:________________________

Name ____________________________Date of Birth:________________________

Name ____________________________Date of Birth:________________________

Name ____________________________Date of Birth:________________________

Name ____________________________Date of Birth:________________________

Name ____________________________Date of Birth:________________________

Name ____________________________Date of Birth:________________________

________________________________ ________________________

Client Signature Date

________________________________ ________________________

Agency Witness Date