



**MAINE HOMELESS MANAGEMENT INFORMATION SYSTEM  
AUTHORIZATION FOR DISCLOSURE OF HEALTH AND/OR PERSONAL INFORMATION**

**For:** \_\_\_\_\_  
(First Name) (Middle) (Last Name) (Date of Birth)

**READ FIRST:** \_\_\_\_\_ ("Participating Agency") participates in a federally funded Maine State Housing Authority ("MaineHousing") program for persons who are homeless. Such participation includes collecting and entering into a Maine Homeless Management Information System ("HMIS") certain personal and demographic information Participating Agency maintains for homeless persons it serves, and such information can also include health care information (such as needs assessment information used to establish your level of housing needs and services) if Participating Agency is a licensed health care provider. Information entered and maintained in the HMIS about you can then be accessed and used by MaineHousing and other participating agencies to evaluate outcomes and the effectiveness of MaineHousing's program in reducing homelessness. Authorizing Participating Agency to collect and enter into the HMIS personal and health care information about you may reduce or eliminate the need for you to be screened repeatedly by each participating agency from which you seek services (i.e., minimize the number of times you have to "tell your story"), allow you to receive services more quickly, and enhance MaineHousing's and participating agencies' ability to provide you with more effective coordinated services to meet your housing needs. If you wish to authorize Participating Agency to disclose your personal and/or health care information to MaineHousing and other participating agencies through the HMIS, please complete and sign this form. Participating agencies who are "covered entities" under HIPAA, may use and disclose your health care information only for purposes authorized by the federal HIPAA Privacy Standards and applicable Maine health care confidentiality law, pursuant to this authorization, and pursuant to each participating agency's own Notice of Privacy Practices, which is posted at each participating agency and should be offered to you by each participating agency from which you obtain services.

**By signing below, I acknowledge, understand and agree that:**

- ✓ My and my dependent children's (identified below) personal and health care information and records are protected by federal and state laws and regulations governing the confidentiality of client records and cannot be disclosed without my written authorization unless otherwise provided for in such laws and regulations. All agencies that participate in the Maine HMIS have an obligation to keep confidential my personal information, identifying information, records, and any health care information, they maintain about me and my dependent children as listed on this form below.
- ✓ *Unless I strike out this sentence*, I intend for this authorization to include disclosure of (i) any mental and behavioral health information maintained by any participating agency that is a licensed mental health agency, facility or program (which I have the right to review at any reasonable time before deciding to authorize its disclosure on this form); (ii) any mental and behavioral health information related to mental health services provided to me by licensed mental health professionals (i.e., psychiatrists, psychologists, clinical nurse specialists, social workers and counseling professionals) at a participating agency; and (iii) any HIV information maintained about me by any participating agency (which disclosure of HIV information could have adverse consequences, including loss or denial of employment, health insurance benefits, life insurance benefits, and other forms of discriminatory treatment, whether lawful or unlawful).
- ✓ *Unless I strike out any of the following*, I intend this authorization to include (i) the disclosure of records and information the disclosing agency has received from other agencies, healthcare providers or facilities, and (ii) subsequent disclosures of information that are within the scope of this authorization.
- ✓ This authorization is also intended to include disclosure of my historical record contained within the HMIS.
- ✓ I authorize the disclosures permitted by this authorization to be made through the HMIS, by fax, mail or orally, as deemed most appropriate by the parties authorized to share my information.
- ✓ None of the parties authorized to share my information under this authorization will receive any payment or other

- remuneration in exchange for disclosing my information, except as may be allowed by law.
- ✓ I may refuse to authorize the disclosure of some or all of the personal or health care information described on this form concerning me or any of my listed dependents below to any of the other collaborating Maine HMIS participating agencies. However, I understand that my refusal could result in improper services or other adverse consequences.
- ✓ Participating Agency will not condition services or treatment on whether I sign this authorization.
- ✓ I may revoke this authorization at any time, in writing, by notifying the Participating Agency in the manner described in Participating Agency's Notice of Privacy Practices, except to the extent that Participating Agency or other persons or entities have already acted in reliance on it. Revocation WILL NOT be retroactive.
- ✓ There is the potential that information disclosed pursuant to this authorization may be redisclosed by persons or entities receiving the information and that, as a result, the information may no longer be protected.
- ✓ Data derived from my information will be used by MaineHousing to report to funders, the Maine Department of Health & Human Services, and for advocacy purposes.
- ✓ All information collected on the Client Profile, Entry, Interim, and Exit Assessments, and the Shelter/Home to Stay prioritization tool will be shared with MaineHousing and other participating agencies through the HMIS to aid and assist service providers in obtaining housing and services for me and/or my household.
- ✓ I have a right to a copy of this signed authorization.

**I have read the foregoing information, or it has been read to me, and I have had the opportunity to ask questions about it and any questions that I have asked have been answered to my satisfaction.**

By signing below, I give permission to the Participating Agency identified above to disclose to and obtain from MaineHousing and the other Maine agencies participating in the Maine HMIS identified on Exhibit A attached, any personal information and health care information that any of these participating agencies maintain about me, or about any of my dependent children who are not authorized by law to authorize such disclosure on their own behalf. I authorize such disclosures for purposes of evaluating my housing service needs, coordinating the delivery of housing services to me, for evaluating outcomes and the effectiveness of the MaineHousing's emergency shelter homeless program in reducing or eliminating homelessness, and for the other uses and purposes described elsewhere on this form above.

This authorization will automatically expire in thirty (30) months, unless I revoke it earlier. To the extent that this authorization authorizes disclosure of any mental health information maintained by a licensed mental health agency, facility or program, this authorization will automatically expire in one (1) year with respect to the disclosure of such mental health information, unless I revoke it earlier.

\_\_\_\_\_  
Signature of Client, Guardian, Health Care Power of Attorney  
or Health Care Surrogate

\_\_\_\_\_  
Date

Provider Use:

- \_\_\_\_\_ did not give permission to share and exchange information with other Maine HMIS participating agencies for the purpose of evaluating services needed and to coordinate service delivery.
  
- \_\_\_\_\_ gave limited permission to share and exchange information with other Maine HMIS participating agencies for the purposes of evaluating services needed and to coordinate service delivery.

**Note: If one of the above boxes is checked FAX this signed form IMMEDIATELY to the Maine HMIS Team at (207) 624-5768**

**EXHIBIT A**  
**Maine Homeless Management Information System**  
**AUTHORIZATION FOR DISCLOSURE OF HEALTH**  
**AND/OR PERSONAL INFORMATION**

**PARTICIPATING AGENCIES**

- Aroostook Mental Health Services, Inc.
- The Bangor Area Homeless Shelter
- Bread of Life Ministries, Inc.
- Catholic Charities Maine

City of Portland

Area IV Mental Health Services Coalition (Common Ties Mental Health Center)

Community Health and Counseling Services

Community Housing of Maine, Inc.

Employment Specialists of Maine, Inc.

Families and Children Together (F.A.C.T.)

H.O.M.E., Incorporated

Homeless Services of Aroostook

Kennebec Valley Mental Health Center

Knox County Homeless Coalition

Maine Bureau of Veterans' Services

Maine Department of Health and Human Services

Maine State Housing Authority

Mid-Maine Homeless Shelter, Inc.

New Beginnings, Inc.

Penobscot Community Health Center

Preble Street

Portland Housing Authority

Rumford Group Homes, Inc.

Rural Community Action Ministry

Shalom House, Inc.

Shaw House

Sweetser

Tedford Housing

The Opportunity Alliance

York County Shelter Programs, Inc.

Western Maine Homeless Outreach

U.S. Department of Veterans Affairs

Veterans Inc.

Volunteers of America Northern New England, Inc.

Client initials: \_\_\_\_\_