Midland County CoC MSHMIS
CLIENT RELEASE OF INFORMATION

Many Michigan shelters and helping programs use the Michigan Statewide Homeless Management Information System (MSHMIS) to keep information about the people that they help. We collect personal information from you that we need to help us, help you. We have strict rules about sharing your information.

Why do we collect information about you?

- Work with other agencies to help you.
- Help case managers work together for you.
- Connect you with other helping agencies. You may be eligible for other benefits.
- Reduce the number of times you tell your story.
- Allow agencies to be paid for their work with you and to help them apply for additional dollars that can be used to help you.
- Help agencies meet their legal obligations.

We need additional identifying information so that you are not confused with someone else. We also need to learn more about your situation to make sure you are eligible for services.

SECTION 1 – Basic Identifying Information

So that agencies that use our HMIS system can find your record, agencies can see the following basic identifying information about you:

- Your name
- Your gender
- The last four digits of your Social Security Number
- Your year of birth
- Your veteran status

We use this information to select the correct record and to better coordinate services for you. All persons using HMIS are trained and certified in privacy.

If you have a specific reason why other HMIS agencies shouldn't be able to find your record in HMIS you can ask to have this basic identifying information secured so that only our agency can see it.

PLEASE NOTE: If you have received services from other agencies who use HMIS we may not be able to secure this information. PLEASE TALK WITH YOUR CASE MANAGER for more information. A separate document has been attached).

I have reviewed the attached document named **"Securing Basic Identifying Information."**
I understand the implications and I am asking that my client profile be secured.
Do not initial here unless you have discussed this with your case manager
Please initial here to secure this basic identifying information _____

SECTION 2 – Acknowledgement of Rights

Many agencies also use the system to improve services delivered to you. The following are your rights concerning your data. Please review and initial in the box next to **each right to show that you understand it. If you have questions, please discuss them with your case manager.**

____	I have received a copy of the Agency's Privacy Notice/script that explains MSHMIS and my rights and responsibilities. It explains how information is kept and shared through this system.
____	**I understand that the confidentiality of my records is protected by law**. I understand that this agency will never give information about me to anyone outside the agency without my specific written consent through a Coordination of Care Sharing Plan or as required by law, including the Federal Law of Confidentiality for Alcohol and Drug Abuse Patients, (42 CFR, Part 2), the Health Insurance Portability and Accountability Act of 1996 (HIPAA, 45 CFR, Parts 160 & 164 as revised by the Health Information Technology for Economic and Clinical Health Act of 2009 aka the HITECH Act), and certain Michigan laws.
____	I can withdraw my consent to share at any time, but any information already shared with another agency cannot be taken back. If sharing information on the system poses an imminent health or safety risk I will talk with my case manager.
____	I understand that I have the right to see my information, request changes, and to get a copy of my information by written request. An agency can refuse to change my record but must provide a written explanation of why they refuse the change within 60 days. Agencies may charge for reproducing a record.
____	I understand that agencies included in my Sharing Plan must follow strict privacy guidelines.
____	I understand that my written consent allows the information listed in Section 3 - Coordination of Care Sharing Plan to be shared among the agencies listed in the sharing plan. All sharing agencies where I am receiving services will update that information as I provide new or additional information. The purpose of sharing my information is to better coordinate care for me and my family.
____	I understand that I will not be denied services (emergency assistance, outreach, shelter, housing assistance, etc.) if I refuse to share information in this system.
____	I understand that my name and other identifying information may be used to match records through a trusted partner for academic research purposes or to determine eligibility for other resources. If I am eligible to receive additional resources, my case manager may contact me. None of my additional identifying information outside of my name will be shared with other organizations unless I sign an additional release of information. Prior to academic research being done, my identifying information will be removed, before data analysis takes place.

This Release is active for one year effective the date of Signature.

Client signature (head of household): _____, Date: _____/_____/_____

Adult Household Member signature: _____, Date: _____/_____/_____

Adult Household Member signature: _____, Date: _____/_____/_____

Adult Household Member signature: _____, Date: _____/_____/_____

Signature of guardian or authorized-representative (when required): _____

Relationship to client: _____ Date signed by guardian/authorized representative: _____