Resident/Service Coordinator – Consent for Release of Information

In order to best serve your needs, to develop meaningful service plans, to determine continuing eligibility for services, and to monitor the quality of services you receive, various "partners" may receive from and/or exchange/share/release information with one another.

I, _____, authorize the staff at _____ apartment complex to obtain and/or disclose information necessary to provide me with supportive services and assistance.

Consent for release of information, although optional, is a critical component of our community's ability to provide the most effective services and assistance possible.

The information contained in case records with each of the below partner agencies/companies is considered confidential and privileged and cannot be exchanged/shared/released without your expressed and informed written consent, except where authorized by law.

I give permission to the following agencies, companies, facilities, etc., to partner with the staff of my building to provide the services I require.

Social Service Agencies	Legal Services	HRDE/HRDF Staff
Medical and Mental Health Facilities	Utility Companies	Senior Centers
Centers for Medicaid/Medicare Services	Nursing Homes	Nutrition Programs
Dept. of Health and Human Services	Rehabilitation Centers	Centers on Aging
Social Security Administration	Banks	Insurance Companies
Family Members	Other _____	Other _____

I authorize and consent to the exchange, sharing and/or release of the following information for the purposes of developing, coordinating and determining eligibility for services, and monitoring services/compliance.

- Identifying information: name, birth date, gender, race, social security number, residential information, phone number, and family information.
- Medical and mental health records (except HIV/AIDS and alcohol and drug treatment), vocational assessment, care coordinators recommendations and direct observations.
- Financial information: income verification, assets and expenses, public assistance payments and allowances, food stamp allotments, utility companies, medical and insurance bills.
- Insurance information: Medicaid, Medicare, supplemental.
- Emergency information: emergency contacts, any known medical conditions.
- Employment information: status, work history, criminal investigation results.
- _____(Resident initial) HIV/AIDs related diagnosis or test results.
- _____(Resident initial) Substance abuse diagnosis, treatment plan, progress in treatment and discharge.
- Other _____

The purpose of this disclosure is to: _____
_____

Information obtained by the service coordinator will be maintained as confidential and released only to those employees who have a need to know such information, as required by law, or as provided in this Release. The service coordinator shall adhere to all applicable laws, regulations or professional license requirements.

I understand that I may revoke this Consent to Release of Information at any time providing written or verbal notice of the revocation to the service coordinator. This revocation will not apply to information that has been previously released or action that has been taken in accordance with, and in reliance upon, this consent.

This consent (unless expressly revoked earlier) expires one hundred eighty days from the date indicated below.

Agency shall give notice of the following to all agencies receiving information disclosed as a result of this signed consent:

Health information disclosed pursuant to this consent may be subject to re-disclosure and would no longer be protected by 45 CFR Parts 160 and 164 unless applicable state law prohibits re-disclosure of the information. Federal law prohibits re-disclosure of substance abuse treatment information to any person without the written authorization in accordance with 42 CFR Part 2.

If the information released includes information of any substance abuse diagnosis, treatment plan, progress in treatment and discharge, the following applies:

Information disclosed pursuant to this consent has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without specific written consent of the persons to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

If the information released includes information of and HIV/AIDS related diagnosis or test results, the following statement applies:

This information has been disclosed to you from confidential records protected from disclosure by state law. You shall make no further disclosure of this information without the specific, written and informed release of the individual to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is not sufficient for this purpose.

This information has been disclosed to you from records protected by federal and state confidentiality rules. Any further release of it is prohibited unless the further disclosure expressly permitted by the person to whom it pertains.

I certify that all statements on this form have been read by me or read to me, and I understand the information.

Signature of Resident: _____ Date:_____
Signature of Guardian, if applicable: _____ Date:_____
Relationship to Resident: _____
Signature of Service Coordinator: _____ Date: _____