

AUTHORIZATION TO DISCLOSE INFORMATION

Agency Name:

PRIVACY STATEMENT: Disclosure of the social security number is voluntary and is requested for the purpose of accurate identification. Failure to disclose a social security number will not affect the disclosure of other information. This agency will not condition services on your agreement to authorize disclosure of your health information.

INSTRUCTIONS: Provide information as it existed when the service was provided.

Name of Client (Last, First, Middle Initial)	Social Security Number	Date of Birth	
Street Address	City	State	Zip

CLIENT RELEASE AND SIGNATURE

1. I Hereby Authorize:

Name of Person/Agency

Street Address	City	State	Zip
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2. To Release Information To: Administrators of the North Dakota Homeless Management Information System
 1600 E Century Avenue Suite 2, Bismarck, ND 58503
 2105 Lee Avenue, Bismarck, ND 58504

3. The following information is requested: name; reporting agency; sex; marital status; sex/age of family members; race/ethnicity; veteran status; income status; current housing status; reason for homelessness; services currently received; unmet needs.

4. The information identified above will be used for: Research and analysis and reporting to the Department of Housing and Urban Development, the US Congress, the North Dakota legislature and communities on the statistics and needs of the homeless in North Dakota for the purpose of increasing funding for housing and services to the homeless. **No personal identifying information will be released, except to the North Dakota HMIS.**

5. This authorization to disclose information remains in effect until _____(Date)
 OR: (Specify Event Terminating Operation of the Release)

CLIENT CONSENT*

This authorization is voluntary and remains in effect until the above date or event, unless specifically revoked by written notice to the agency or person. Refer to the Privacy Notice for further description of revocation rights. Any information disclosed prior to written revocation of this authorization shall not be a breach of confidentiality. A photocopy of this authorization is as effective as the original. Unless otherwise agreed to in writing, information may be disclosed under this authorization in any form or medium, including, but not limited to, oral, written, or electronic transmission.

*I have been provided with a copy of the North Dakota HMIS Privacy Notice _____ (Client's Initials)

Signature of Client	Date
Signature of Parent/Guardian or Custodian (if needed and relationship)	Date
Signature of Witness (if needed)	Date

___ CHECK IF APPLICABLE - NOTICE TO WHOMEVER DISCLOSURE IS MADE CONCERNING ADDICTION RECORDS
 This information has been disclosed to you from records protected by Federal confidentially rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the disclosure of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

NOTICE: Except for information subject to 42 CFR Part 2, information disclosed to another entity may potentially be redisclosed, in which case it may not be protected by state or federal law.

*I authorize the release of the indicated sensitive status (client to initial)
 Mental Health _____ (initial)
 HIV or AIDS _____ (initial)
 Chemical Dependency _____ (initial)