

# Orange County Continuum of Care

## HMIS Client Consent form

Welcome to the Orange County Continuum of Care, and a project participating in the Orange County HMIS (OC HMIS)! HMIS stands for **H**omeless **M**anagement **I**nformation **S**ystem, and it is a secure database used to collect and store information about clients served at this agency.

In Orange County, all agencies that participate in entering client data in HMIS share that data with each other. This means that if you complete a program participating in the OC HMIS and later need assistance at another program that also participates in the OC HMIS, staff at the second agency will search for your name and find your profile. Then you will be asked to confirm your existing information in HMIS (like your name, date of birth, and social security number). The second agency will be able to see what kind of services you've received in the past.

Because the OC HMIS contains such sensitive data Orange County takes your privacy very seriously. **The following protections for your data are in place:**

- Individual client data is only viewable by qualified staff at each participating agency.
- In order to participate in the OC HMIS, leaders at each agency must sign an Agency Agreement that includes a commitment to protecting client data and maintaining confidentiality.
- In order to use HMIS, agency staff must pass multiple trainings that each go over the importance of client privacy.
- The OC HMIS is hosted on a secure server and data is encrypted. This means that anyone attempting to "hack into" HMIS will only see gibberish, never any client data.

**What information is shared in the HMIS database?** We share both Protected Personal Information (PPI) and general information obtained during your intake and assessment, which may include but is not limited to:

- Your name and your contact information
- Your social security number and Date of Birth
- Your basic demographic information such as gender and race/ethnicity
- Your history of homelessness and housing (including your current housing status, and where and when you have accessed services)
- Your *self-reported* medical history and disability status, including mental and physical health concerns, substance abuse history, and HIV/AIDS status
- Your case notes and services
- Your income sources and amounts; and non-cash benefits
- Your veteran status
- Information about other members of your household
- Your *self-reported* history of domestic violence
- Your photo (optional)

**By signing this form, you understand the following:**

- You have the right to receive services, even if you do not sign this consent form. Providers may not refuse to provide you with services based on your refusal to sign this form.
- You have the right to receive a copy of this consent form for your records.
- Your consent permits any participating organization to add to or update your information in HMIS, without asking you to sign another consent form. This consent form is valid for seven (7) years after the signature date.
- You may revoke your consent at any time, but your revocation must be provided either in writing or by completing the Revocation of Consent form. The agency you are receiving services from must make this form available to you if you ask, and it should be out and available for you to take from the office or

If you feel any of your rights outlined in this document have been violated, please contact (714) 589-2360.

facility you receive services from. Upon receipt of your revocation, we will remove your PPI from the shared HMIS database and prevent further PPI from being added. The PPI that you previously authorized to be shared cannot be entirely removed from the HMIS database and will remain accessible to the limited number of organization(s) that provided you with direct services.

- Participating agencies are required to post a Privacy Notice at each location where intakes are completed. You should be able to see this notice, which contains more detailed information about how your information may be used and disclosed. You have the right to receive a copy of this notice for your records.
- You have the right to request, in writing, the following pieces of information within five (5) business days of your request:
  - A correction of inaccurate or incomplete PPI
  - A copy of your consent form
  - A copy of your HMIS record (agency staff must review this information with you if you request such a review so that you can fully understand the information presented to you and how it is used)
  - A current list of participating agencies that have access to HMIS data
- Aggregate or statistical data that is released from the HMIS database will not disclose any of your PPI.
- You have the right to file a grievance against any organization whether or not you sign this consent. The Client Grievance Form should be out and available for you to take from the office or facility you receive services from.
- You are not waiving any rights protected under Federal and/or California law.

**SIGNATURE AND ACKNOWLEDGEMENT**

Your signature indicates that you have read (or been read) this client consent form, have received answers to your questions, and you freely consent to have your information, and that of your minor children (if any), entered into the HMIS database. You also consent to share your information with other participating organizations as described in this consent form.

Client Name: \_\_\_\_\_ DOB: \_\_/\_\_/\_\_

Signature: \_\_\_\_\_ Date Signed: \_\_/\_\_/\_\_

**Minor Children (if any):**

Name: \_\_\_\_\_ DOB: \_\_/\_\_/\_\_      Name: \_\_\_\_\_ DOB: \_\_/\_\_/\_\_

Name: \_\_\_\_\_ DOB: \_\_/\_\_/\_\_      Name: \_\_\_\_\_ DOB: \_\_/\_\_/\_\_

**Agency Staff Signature:**

Agency Staff Name: \_\_\_\_\_ Agency Staff Signature: \_\_\_\_\_

Agency Name: \_\_\_\_\_ Date: \_\_/\_\_/\_\_