Anne Arundel And Annapolis Coalition To End Homelessness
Authorization to Use or Disclose Protected Health Information (PHI)

Section 1. Who is the Individual

Last Name:	First Name:	Middle Initial:
Provider Completing Assessment:	Date Of Birth:	Social Security Number:

I hereby authorize the use or disclosure of protected health information about the individual named above

I am: ☐ the individual named above (complete Section 8 below to sign this form)

☐ A personal representative because the patient is a minor, incapacitated, or deceased (complete section 9 below)

Section 2. Who Will Be Disclosing Information About the Individual?

The following person(s) or entity may use or disclose the information:
All providers within the Anne Arundel and Annapolis Continuum of Care (Anne Arundel And Annapolis Coalition To End Homelessness) who utilize the Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-SPDAT) pre-screen assessment and the Homeless Management Information System (HMIS) including: Anne Arundel County Department Of Social Services, Anne Arundel County Partnership For Children, Youth, & Families, Arundel House Of Hope, Anne Arundel County Mental Health Agency, Anne Arundel County Department Of Health, Anne Arundel County Public Schools, Arundel Lodge Inc, Alliance Inc, Arundel Community Development Services (ACDS), Anne Arundel Crisis Response System, Blessed In Tech Ministries Inc, Housing Commission Of Anne Arundel County (HCAAC), The Light House, People Encouraging People, Sarah's House Catholic Charities, We Care & Friends, CRi, YWCA, Allcare Treatment Service, TIME Organization, Veterans Administration, Happy Helpers for the Homeless, Community Action Agency, The Salvation Army, Prologue Inc, Annapolis Benevolence Coalition, and PDG Rehab.

Section 3. Who Will Be Receiving Information About The Individual?

The information may be disclosed to:
All providers within the Anne Arundel and Annapolis Continuum of Care (Anne Arundel and Annapolis Coalition To End Homelessness) who utilize the Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-SPDAT) pre-screen assessment and the Homeless Management Information System (HMIS) including: Anne Arundel County Department Of Social Services, Anne Arundel County Partnership For Children, Youth, & Families, Arundel House Of Hope, Anne Arundel County Mental Health Agency, Anne Arundel County Department Of Health, Anne Arundel County Public Schools, Arundel Lodge Inc, Alliance Inc, Arundel Community Development Services(ACDS), Anne Arundel Crisis Response System, Blessed In Tech Ministries Inc, Housing Commission Of Anne Arundel County (HCAAC), The Light House, People Encouraging People, Sarah's House Catholic Charities, We Care & Friends, CRi, YWCA, Allcare Treatment Service, TIME Organization, Veterans Administration, Happy Helpers for the Homeless, Community Action Agency, The Salvation Army, Prologue Inc, Annapolis Benevolence Coalition, and PDG Rehab.

Section 4. What Information About the Individual Will Be Disclosed?

The information to be disclosed may include records on drug abuse, alcoholism, behavioral health, mental health, sickle cell anemia, human immunodeficiency virus (HIV) infection, acquired immunodeficiency syndrome (AIDS), or tests for HIV information. The information to be disclosed, including behavioral health and/or substance abuse services includes the following:

All information contained within the Vulnerability Index and Service Priotization Decision Assistance Tool (VI-SPDAT) pre-screen assessment and the 2020 HMIS Data Standards, including

A. History of Housing and Homelessness
B. Risks and Income
C. Socialization and Daily Functioning
D. Wellness

Section 5. What is the Purpose of the Disclosure?

To improve access and service alignment by assessing various health and social needs, and then to match those assessed with the most appropriate housing interventions available. The VI-SPDAT is a tool to help guide those assessed to appropriate services and housing opportunities and HMIS is the information system used by homeless services agencies across Anne Arundel County to collect information about the persons they serve.

Section 6. What is the Expiration Date or Event?

This authorization will expire 2 years from the date this document was signed in Section 8 or Section 9 below.

Section 7. Important Rights and Other Required Statements You Should Know

- You can revoke this authorization at any time by writing to the Anne Arundel and Annapolis Coalition To End Homelessness, at 2666 Riva Road 2nd Floor, Annapolis, MD 21401. Any revocation will not apply to information that has already been used or disclosed.
- The information disclosed based on this authorization may be redisclosed by the recipient and may no longer be protected by federal or state privacy laws. Not all persons or entities have to follow these laws.
- No disclosure will be made where authorization has expired, fails to meet a requirement of 42 CFR Part 2, is revoked, or is known to be false or through reasonable effort could be known to be false.
- If you refuse the authorization or revoke the authorization, you will continue to receive all the medical care and benefits for which you are eligible. You do not need to sign this form in order to obtain enrollment, eligibility, payment, or treatment for services and these cannot be a conditioned on signing this authorization.
- This authorization is completely voluntary, and you do not have to agree to authorize any use or disclosure.
- You have a right to a copy of this authorization once you have signed it. Please keep a copy for your records, or you may ask us for a copy at any time by writing to Anne Arundel and Annapolis Coalition To End Homelessness, at 2666 Riva Rd 2nd Floor, Annapolis, MD 21401.
- If you have any questions about anything on this form, or how to fill it out, we can help. Please call the Homeless Coordinator at 410-269-4749.

Section 8. Signature of the Individual

Signature _____ Date (required) _____

Section 9. Signature of Personal Representative (if applicable)

Signature _____ Date (required) _____

Please describe your relationship to the individual and/or your legal authority to act on behalf of the individual in making decisions related to healthcare. You may be asked to provide us with the relevant legal document giving you this authority.

Relationship to the individual (required) _____

Notice To Recipient of information

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization of the release 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.