Mainstream Voucher & Coordinated Access for Adults and Families:

Authorization for Disclosure of Confidential Information

The Mainstream Voucher Program provides rental assistance to assist households which include non-elderly persons (age 18 to 61) with disabilities who are transitioning out of institutional or other segregated settings, at risk of institutionalization, homeless, or at risk of becoming homeless. **Coordinated Access for Adults and Families** is a network of separate agencies that coordinate the delivery of rental assistance and supportive services to individuals and families, primarily who are homeless, with priority for those with the longest history of homelessness and most service needs. This network partners with Home Forward to coordinate services for Mainstream Voucher recipients. A full list of Coordinated Access for Adults and Families partner agencies is available upon request and published online at ahomeforeveryone.net/coordinatedaccess.

Coordinated Access for Adults and Families agencies will enter the information you provide into a vendor-hosted Homeless Management Information System (HMIS), a computerized and secured record-keeping system known as ServicePoint. These agencies are required by law to maintain the privacy of your personal information. Your information will not be disclosed to other agencies without your authorization except as required or permitted by law.

By signing this form, I authorize the disclosure of my Client Record [Name, Social Security Number, and Veteran Status], Demographics [Date of Birth, Gender, Race, and Ethnicity], Mainstream Voucher and Coordinated Access related Program Enrollment and Exit Information, information about the nature of my situation, and Services and Referrals I receive, to Coordinated Access for Adults and Families partner agencies for the purpose of payment, health care operations activities and coordination of housing and related services.

I authorize the disclosure of the following categories of personal information (all adult household members participating in services initial):	
A. Mental Health	Initial/s: _________
B. Substance use disorder diagnosis, treatment, and treatment referral. I understand that records disclosed made may be bound by Part 2 of Title 42 of the Code of Federal Regulations (CFR) governing confidentiality of substance use disorder records. Recipients of these records may re-disclose the records only with my written consent or as permitted by 42 CFR Part 2.	Initial/s: _________
C. HIV/AIDS	Initial/s: _________

I understand that this information may include information that would otherwise be protected by Oregon and federal law. All Coordinated Access for Adults and Families participating agencies acknowledge that any information disclosed among these agencies will not be re-disclosed to other parties without my further written authorization, unless otherwise required or permitted by law.

This authorization becomes effective on the date below and <u>will expire 12 months from my last date of participation in The Mainstream Voucher Program and/or Coordinated Access for Adults and Families</u>; a period reasonably needed to complete the disclosure of information for the purposes described and named in this authorization <u>unless I indicate otherwise</u>. ☐ Specific expiration date: ____________.

I may revoke this authorization at any time except to the extent that action has already been taken in reliance on it. Revocation of this authorization is effective upon receipt by a Coordinated Access for Adults and Families agency.

<u>This authorization is voluntary.</u> I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits. Refusing to sign this authorization may affect my engagement with Coordinated Access for Adults and Families, shared prioritization lists, and access to partner agencies. I may inspect or copy any information used and/or disclosed under this authorization. My signature below indicates I approve of this authorization and understand its meaning.

Please list the names and dates of birth of all household members participating in services:

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_________________________________ _________________________________ ______________

Client or Legal Guardian Name (please print) **Client or Legal Guardian Signature** **Date**

_________________________________ _________________________________ ______________

Additional Adult's Name (please print) **Additional Adult Signature** **Date**

ONLY COMPLETE THIS SECTION TO REVOKE PREVIOUS AUTHORIZATION

I revoke this authorization. **Signature:** ____ **Date:** __________

Signature: ____ **Date:** __________