Appendix H: Sample Interagency Sharing Form

Standard Client Authorization

To Release and Exchange Basic Information with the Clearinghouse[9]

Name of Agency:

Client's Last Name:

First Name:

Middle Initial:
Date of Birth:

Social Security Number (optional):

The Continuum of Care Clearinghouse Project is a shared homeless and housing management information system. The Clearinghouse is administered by the nonprofit organization Community Council of Central Oklahoma to help improve homeless and housing services. The Clearinghouse does this by allowing **authorized personnel** at Clearinghouse Member Agencies to share client information needed for service delivery, to use an online directory of community services, and to track demographic trends and service patterns. The Clearinghouse operates over the Internet and uses many security protections to help ensure the confidentiality of your records.

I understand that all information gathered about me is personal and private and that I do not have to participate in the Clearinghouse. I have had an opportunity to ask questions about the Clearinghouse and to review the basic identifying information this release authorizes the Clearinghouse Member Agencies to share. I also understand that information about nonconfidential services provided to me by Clearinghouse Member Agencies may be shared with other Clearinghouse Member Agencies. Unless I make a formal request to a Clearinghouse Member Agency that I no longer want to participate in the Clearinghouse, this release will remain in force for 3 years from today and will expire on _____(d/m/y).

I authorize _____ as a Clearinghouse Member Agency, to share my basic identifying information and nonconfidential service information with other Clearinghouse Member Agencies. I authorize that a copy of this original will serve as an original for the purposes stated above.

_____ _____
Client's Authorizing Signature Date (d/m/y)

Based on the above information, I authorize basic identifying information and nonconfidential service transactions of my dependent(s) to be shared with the Clearinghouse.

_____ _____
Legal Guardian's Authorizing Signature Date (d/m/y)

_____ _____
Legal Guardian's Printed Name Date (d/m/y)

_____

[9] The original of this Client Authorization for Release form should be kept on file at the Agency. Upon a form's expiration date, the file should be kept for five years.

Name of Dependents that the Legal Guardian Authorizes to Participate in the Clearinghouse**:**

Name	DOB	Name	DOB
Name	DOB	Name	DOB

Agency Representative's Signature — Date (d/m/y)

Agency Representative's Printed Name — Date (d/m/y)

Description for Informed Decision**:**

__ Verbal Explanation

__ Interpreter

__ Written

<u>Basic identifying information this release authorizes to be exchanged among Clearinghouse Member Agencies**:**</u>

Date and Time of Intake into the Clearinghouse System
Permission for Information Release
First Name
Middle Initial
Last Name
Alias
Social Security Number
Driver's License ID
U.S. Citizen Status
Immigration Status
Registered to Vote
Address
Home Telephone
Work Telephone
Emergency Contact and Telephone
Date of Birth/Birthday
City and State of Birth
Sex
Race
Primary Language

Marital Status

Other notes/comments (**CANNOT** include confidential information such as TB diagnosis, drug and alcohol information, mental health information, etc.)

Household Relationships

Basic Identifying Information on Household Relationships (same questions as above)

This release also authorizes Clearinghouse Member Agencies to share relevant, nonconfidential information about services provided with other Clearinghouse Agencies, such as**:**

Shelter stays

Food

Clothing

Transportation

Employment

Housing

Childcare

TB Clearance Status

Utility Assistance

_____ _____

Authorizing Person's Initials Date (d/m/y)