The Community Partnership for the Prevention of 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 Washington, D.C. continuum of care who utilize the Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-SPDAT) pre-screen assessment and/or Service Prioritization Decision Assistance Tool (SPDAT)

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

The information may be disclosed to:

All providers within the Washington, D.C. Continuum of Care who utilize the Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-SPDAT) pre-screen assessment and/or Service Prioritization Decision Assistance Tool (SPDAT)

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

The information to be disclosed may include records on drug abuse, alcoholism, 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 Prioritization Decision Assistance Tool (VI-SPDAT) pre-screen assessment, including:

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

All information contained within the Service Prioritization Decision Assistance Tool (SPDAT), including:

A. Self-Care and Daily Living Skills
B. Meaningful Daily Activity
C. Social Relationships and Networks
D. Mental Health and Wellness
E. Physical Health and Wellness
F. Substance Use
G. Medication
H. Personal Administration and Money Management
I. Personal Responsibility and Motivation
J. Risk of Personal Harm/Harm to Others
K. Interaction with Emergency Services
L. Involvement in High Risk and/or Exploitive Situations
M. Legal
N. History of Homelessness and Housing
O. Managing Tenancy

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 and SPDAT are tools to help guide those assessed to the appropriate services, assist with the case planning process and track changes over time — for those clients that are referred to a case management team as a result of their SPDAT score.

Section 6. What is the Expiration Date or Event?

This authorization will expire 1 year 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 Community Partnership for the Prevention of Homelessness, at 801 Pennsylvania Avenue SE Suite 360, Washington, D.C. 20003. If you revoke this authorization, it 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.
- 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.
- The unauthorized disclosure of mental health information violates the provisions of the District of Columbia Mental Health Information Act of 1978 (§§ 7-1201.01 to 7-1207.02). Disclosures may only be made pursuant to a valid authorization by the client or as provided in title III or IV of that Act. The Act provides for civil damages and criminal penalties for violations.
- 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 The Community Partnership for the Prevention of Homelessness, at 801Pennsylvania Avenue SE Suite 360, Washington, D.C. 20003.
- If you have any questions about anything on this form, or how to fill it out, we can help. Please call The Community Partnership for the Prevention of Homelessness, at 202-543-5298.

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 for 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.