Lake County Release of Information for ServicePoint and Coordinated Entry

Section 1. Who is the Individual?

Last Name:	First Name:	Middle Initial:
Date of Birth:	Social Security Number:	Individual Completing Assessment:

I hereby authorize the use or disclosure of demographic and protected health information about the individual named above, as well as the entry of this information into the ServicePoint® system. ServicePoint® is an information system shared by the Lake County Coalition for the Homeless that helps us improve service delivery and evaluate the effectiveness of services provided.

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

☐ a personal representative because the individual 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 entities may use or disclose the information: All individuals or agencies who are authorized to utilize the Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-SPDAT) pre-screen assessment and/or ServicePoint® which includes homeless services and housing providers in Lake County.

Section 3. Who Will Be Receiving Information About the Individual?
The information may be disclosed to: All individuals or agencies who are authorized to utilize the Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-SPDAT) pre-screen assessment and/or ServicePoint® which includes homeless services and housing providers in Lake County.

Section 4. What Information About the Individual Will Be Disclosed?
The information to be disclosed may include demographic information as well as records on drug abuse, alcoholism, sickle cell anemia, human immunodeficiency virus (HIV) infection, acquired immunodeficiency syndrome (AIDS), or tests for HIV information. The non-demographic information to be disclosed, including behavioral health and/or substance abuse services, comprises the 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
E. Self-Care and Daily Living Skills
F. Meaningful Daily Activity
G. Social Relationships and Networks
H. Mental Health and Wellness
I. Physical Health and Wellness
J. Substance Use
K. Medication
L. Personal Administration and Money Management
M. Personal Responsibility and Motivation
N. Risk of Personal Harm/Harm to Others
O. Interaction with Emergency Services
P. Involvement in High Risk and/or Exploitive Situations
Q. Legal
R. History of Homelessness and Housing
S. 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 and social service interventions available.

Section 6. What is the Expiration Date or Event?
This authorization will expire three 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. If you revoke this authorization, it will not apply to information that has already been used or disclosed.
- You have the right to file a grievance if you feel your rights have been violated
- 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.

Section 8. Signature of the Individual
I have read and understand the above material and I hereby consent that _____ enter the information for me or my child(ren)/ward(s)/dependent(s) into ServicePoint® and to disclose information as outlined in this release.

Client/Parent/Guardian (Signature) Date	Employee Signature Date
Print Name	Print Name
Name of Child/Ward/Dependent (Under 18)	Title/Agency
Name of Child/Ward/Dependent (Under 18)	
Name of Child/Ward/Dependent (Under 18)	

Section 9. Signature of Personal Representative (if applicable)

Client/Parent/Guardian (Signature) Printed Name Date

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. _____

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. 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.