Gavin Newsom
Mayor

PROJECT HOMELESS CONNECT

A joint effort of Department of Public Health, Human Services Agency, Nonprofit Service Organizations and Caring Community Volunteers

Authorization to Share Protected Personal Information

Form #

Client _____ _____ _____

First **M.I.** **Last**

SS# _____ **DOB** _____ _____

I, _____ (AKA) _____

authorize staff and volunteers involved with **PROJECT HOMELESS CONNECT on Oct. 18, 2005** to obtain and share personal information about me during the course of my participation in Project Homeless Connect, including information about my living situation, my health, my economic situation, and other personal information.

I understand that the purpose of obtaining and sharing this information is so that they can help me gain access to the services, appointments and resources I need, such as housing, medical treatment, behavioral health treatment, social services, entitlements, etc.

By checking in the spaces below, I specifically authorize Project Homeless Connect Staff to obtain and share specific protected classes of health information about me as follows:
INITIAL below for protected classes of information:

[___] Mental Health Treatment **[___]** Substance Abuse Treatment

[___] HIV/AIDS Test/Treatment **[___]** Developmental Disabilities

I understand the San Francisco Homeless Outreach Team (43 Fell St., San Francisco, CA 94103) will maintain this signed authorization form.

MY RIGHTS: I understand that this authorization is voluntary. If I refuse to sign this authorization, it will not prevent me from partaking in Project Homeless Connect, but it may limit my ability to access certain services.

I understand that my authorization for this release of information is effective from today, October 18 through November 30, 2005 (six weeks). I understand, however, that I may cancel my authorization at any time by writing a note of cancellation and giving it to a member of the Homeless Outreach Team at the address above. I also understand that when I give or cancel my authorization, it is effective from that date forward, and not retroactively.

_____ _____ _____
Date Signature (Patient/Client/Parent/Guardian/Conservator) Relationship if not Client

_____ **[__]** _____
Witness (Required if Patient/Client unable to sign) Check and Name if Interpreter used.

EXIT INTERVIEW: (Note specific responses)

Did you get what you came for? ❑ Yes ❑ No

If no, what didn't you get? Why not?

_____

_____

_____

What one thing did you like best?
❑ People/Volunteers
❑ Services
❑ Everything
❑ Food
❑ Other _____

Comments: _____

_____

If you could change something about today, what would it be?

_____

_____

7/15/05 – Revised