RELEASE OF INFORMATION (ROI)

Client Authorization for the Release/Exchange of Confidential Information

Client Name: _____

Date of Birth: _____ / _____ / _____

Phone Number: _____

PURPOSE:

I, the undersigned, authorize the release and/or exchange of confidential information for the purposes of service coordination, housing assistance, case management, care planning, benefit eligibility, program referrals, and continuity of care.

PARTIES TO WHOM INFORMATION MAY BE RELEASED OR OBTAINED:

I authorize the **release of and/or obtainment of information** between the following organizations:

- Henning Inc.
- NeighborWorks Alaska
- Anchorage Coalition to End Homelessness
- RurAL CAP
- United Way of Alaska
- New Life Development
- Covenant House Alaska
- Choosing Our Roots
- Anchorage Health Department
- Alaska Housing Finance Corporation (AHFC)

INFORMATION TO BE SHARED **(check all that apply but the first two are required for this program):**

- ☐ Identification and Contact Information
- ☐ Housing History and Homeless Status
- ☐ Case Management/Supportive Services
- ☐ Notes Mental Health and/or Substance Use Information
- ☐ Financial/Income/Benefit Verification
- ☐ Criminal History
- ☐ Medical Information (if applicable and protected by HIPAA)
- ☐ Program Enrollment and Participation Details

Other (specify): _____

RELEASE OF INFORMATION (ROI)

METHOD OF SHARING:

☐ Verbal Communication
☐ Written Reports/Documents
☐ Electronic Communication (e.g., email, secure portal)

DURATION OF AUTHORIZATION:

☐ This authorization shall remain in effect for 12 months from the date signed.
☐ Until (specify date): ____ / ____ / _____
☐ Until services are no longer being provided by NeighborWorks Alaska
☐ Other (specify): _____

RIGHTS AND CONDITIONS:

* I understand that I have the right to revoke this authorization at any time in writing. Revocation does not apply to information already disclosed under this authorization.
* I understand that services provided by NeighborWorks Alaska or other listed organizations will not be denied if I refuse to sign this authorization, except when services require disclosure of information to determine eligibility or program coordination.
* I understand that the information disclosed may be subject to re-disclosure by the recipient and may no longer be protected under federal confidentiality laws.
* I understand that I have a right to request a copy of this signed authorization.

CLIENT CONSENT:

Client Signature: _____ (if done on-line/on phone please type name)

Date: ____ / ____ / _____

Parent/Guardian or Legal Representative (if applicable):

Name: _____

Signature: _____

Relationship: _____

Date: ____ / ____ / _____

Witness (Optional): _____

Signature: _____

Date: ____ / ____ / _____