This consent facilitates referral for housing, treatment, case management, treatment planning,

coordination of medical care and other services. By checking the boxes below and signing this

form on page 2, the types of information listed below can be disclosed.

**Printed Client Name AKA Date of Birth**

I hereby consent to communication about me and my responses to this survey to be disclosed

and received between (agency requesting release):

**Agency Name Address Phone**

and the following organizations that participate in the Coordinated Entry System which include:

***\*\*Please list local agencies here\*\****

Other Agencies Not Listed Above *(please list name of agency completing VI-SPDAT if not included above)*:

**A full list of participating agencies can be found at: *\*\*Please list local website\*\****

I give my permission for the information in the following areas to be disclosed:

[ ]  **The number calculated by the VI-SPDAT, and specific responses related only to determining eligibility and addressing specific barriers to housing.** These records will beused/disclosed for the sole purposes of: VI-SPDAT application, housing navigation and housingplacement through the Coordinated Entry System. \_\_\_\_\_\_\_\_ (initial)

[ ]  **Other:**

(if requesting a copy of records relating to drug or alcohol abuse, HIV status, genetic testing, psychotherapy notes or mental health records, a separated, targeted release is required.) \_\_\_\_\_\_\_\_\_ (initial)

I understand that the information from the VI-SPDAT will be entered into the Coordinated Entry System database. My personal information will be kept in accordance with federal, state, and local laws and regulations related to protecting personal information. I understand this database operates over the Internet, and that my information may remain in the database past the expiration of this consent.

I understand that my alcohol and/or drug treatment records may be protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse patient Records, 42 Code of Federal Regulations (CFR) part 2 or Colorado C.R.S. 27-28-113 & 27-82-109 pertaining to the records of persons using alcohol or drugs. The Federal rules prohibit further disclosure of this information. Other treatment information may be covered under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 CFR, Parts 160 & 164. This release does not prevent other agencies from releasing information otherwise authorized by law.

The purpose of this disclosure is at my request. I understand that any disclosure of information carries with it the potential for re-disclosure and once the information is disclosed, it may no longer be protected by federal HIPAA confidentiality rules; however, if this information is protected by the Federal Substance Abuse Confidentiality regulations, 42 C.F.R. part 2, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I also understand that this consent is subject to revocation at any time, except to the extent that

the members of the Colorado Balance of State Continuum of Care have already taken action in

reliance upon it. If not previously revoked, the consent will expire one year from the date signed

or on this specific date: \_\_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_\_ (day/month/year).

I understand that law enforcement cannot use any information obtained from drug/alcohol

treatment as the basis for subsequent criminal prosecution. I understand signing this disclosure

form is voluntary. The health care provider will not condition treatment, payment, enrollment in

a health plan, or eligibility for benefits on whether or not I sign this form for the requested use

or disclosure.

Client Signature Printed Name Date

Medical Proxy/Guardian Signature Printed Name Date

Witness Signature Printed Name Date

Please return completed ROI with VI-SPDAT version 1.0 – revised 9/29/2017