Mental Health America of the Heartland

Name: _____ **SS#:** _____-____-_____

AUTHORIZATION TO SHARE INFORMATION

The confidentiality of client records is maintained by this agency. The agency will not disclose information to others outside the program that the client may be involved in, information identifying a client as a participant in a program of MHAH or any information or records directly related to the services being provided to such individual with the exception of:

1. The client waives the confidence in writing.
2. When required under the law.

Advocacy/Support Services Records — Written Consent to Share

____ I authorize the staff of the Mental Health America of the Heartland (MHAH) to share my client records to medical and/or mental health personnel in a medical or mental health emergency.

____ Not Applicable

____ I authorize the staff of MHAH to share my records for the purpose of advocating my needs and wishes regarding services and treatment. I further authorize release to qualified personnel of the following agencies for the purpose of research, contractual auditor, or program evaluation and to share information with MHAH for the same purposes.

_____	_____
Agency	Agency
_____	_____
Agency	Agency
_____	_____
Agency	Agency

Housing/Rental Subsidies

____ I authorize MHAH, its associates, employees, or agents, to discuss any pertinent information relating to my housing needs with the individuals, organizations or companies to whom I make payments for services or goods received. I also authorize those individuals, organizations or companies to release to the MHAH what ever confidential financial/medical information they may have in their possession relating to me and to make arrangements with the MHAH whereby my housing needs may be met.

____ **Not Applicable**

MAACLink

I authorize the Mental Health America of the Heartland (MHAH) to collect and enter my personal information into the MAACLink computer database.
I understand that the MAACLink system is used by other agencies in my community for the purposes of:

1. Accurately assessing the needs of low-income, homeless or other special-needs individuals in order to better assist them in improving their current or future situations.
2. Improving the quality of care and service for those in need.
3. Tracking the effectiveness of efforts to meet the needs of the people who have received assistance.
4. Reporting demographic data on an aggregate level that is not individually identified.

Specific information to be entered may include one or more of the following:

- Residency status and dates residing in Supported Housing Program, or receiving services
- Name, age, social security number, ethnicity, date of birth, and previous addresses
- Source and amount of income at entry and exit from program
- Case notes
- Services provided
- Destination at exit of program
- Reasons for exit from program

The purpose of this authorized disclosure is to coordinate services and to compile demographic information about the persons served and services provided. I understand that I may revoke this consent at any time except to the extent that information has already been shared or action has already been taken.

Audit

I authorize MHAH to release my information to Pickett, Cheney, & McMullen, LLP or _____ for purposes of agency financial audit or oversight.

Release of Liability

I understand that, in accordance with the *Privacy Rule of the Health Insurance Portability and Accountability Act* (H.I.P.A.A.), **my personal identifiable physical or mental health information will not be shared** with any other agency without my consent. Such information shall be entered into the MAACLink system, but in a protected format that is only accessible to the person or persons who provided the service. All Agency Representatives who use the MAACLink system have been specially trained in confidentiality measures and have signed Confidentiality Forms within the MAACLink shared data community.

I hereby release MHAH from any liability for information furnished pursuant to this authorization. I understand that my records may include HIV, psychiatric, alcohol or drug abuse information. I understand that my records are protected under the federal and state confidentiality regulations and cannot be released without my written consent unless otherwise provided for in the regulations. New Federal regulations prohibit MHAH from making any further disclosure of information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

A photocopy of this authorization shall be considered as valid as the original.

Signatures

_____	_____	_____
Client Signature	Guardian Signature	Date Signed
_____	_____	_____
Client Name, Please Print	Guardian Name, Please Print	Date
_____	_____	_____
Witness Name, Please Print	Witness Signature	Date

Revocation

I understand that I may revoke this consent (in writing) at any time unless action has already been taken. This consent will expire 1 year after termination of services.

_____	_____	_____
Revocation Date	Name	Witness

Please complete and return to:
Mental Health America of the Heartland
739 Minnesota Ave., Kansas City, KS 66101