

## Louisiana Services Network Data Consortium Release of Information

When you request or receive services from \_\_\_\_\_ (agency name), we collect information about you and your household and enter it into the computerized Louisiana Services Network Data Consortium (LSNDC) System. This program helps us to better understand homelessness, to improve service delivery to the homeless, and to evaluate the effectiveness of services provided to the homeless. LSNDC System is used by over one hundred social service agencies throughout the state that provide services to homeless and low-income persons. Collectively, data on the homeless population in Louisiana (but not personal identifying information) is used in statewide reports on homelessness.

**What information is collected?** Depending on your situation, you may be asked for some or all of the following:

- **Basic identifying information** (name, SSN, date of birth, gender, race, marital and family status, household relationships, phone numbers, military veteran status)
- **Housing information** (address, type of housing, homeless status, reason for homelessness)
- **Income information** (sources and amounts of household income, employment information, work skills)
- **Legal history/information** (US Citizenship, immigration status and sponsorship, arrest/conviction/parole records, domestic violence/sexual assault offender)
- **Medical information** (disability and general health status, pregnancy, immunizations, health care provider/ physician, medical problems/allergies, hospitalizations, insurance, HIV/AIDS, Tuberculosis, dental 1yr)
- **Services** needed and provided; outcomes of services provided

**Why should you agree to have your information shared with other agencies that use the LSNDC System?**

**By sharing your information with these agencies, you will help them:**

- Identify other services or programs you may be eligible for,
- Better coordinate services for you and your household,
- More accurately count the number of homeless persons, services available and services needed,
- Show the people who fund homeless programs that the services are needed and
- Obtain other funding for programs that serve homeless persons.

### **CLIENT INFORMED CONSENT/RELEASE OF INFORMATION AUTHORIZATION**

You have the option to restrict access to personal information that you are providing about yourself and your minor children. You may modify this consent with respect to the sharing of your information at any time.

Except for domestic violence, unaccompanied youth, physical health, mental health, substance abuse and HIV/AIDS status information, you have my consent to share all other information about me with other LSNDC Partner Agencies unless specified otherwise below. These items require my signature on a separate form named Confidential Release.

My information should not be shared with the following program/agencies: \_\_\_\_\_

My information may only be shared with authorized personnel in the following program/agencies: \_\_\_\_\_

Information about me may only be shared with authorized personnel within this agency.

#### **My Rights:**

- |   |
|---|
| <input type="checkbox"/> I may see and request a copy of any information used/disclosed (as permitted by federal or state law)  |
| <input type="checkbox"/> I understand that I can refuse to sign this authorization and my refusal will not affect my ability to obtain services, payment of services, or my eligibility for benefits.   |
| <input type="checkbox"/> I can cancel this authorization in writing, at any time, but if I do, it won't affect actions taken before _<br>(agency name) receives the cancellation. I can send the notification to cancel authorization to _____<br>(agency address). |
| <input type="checkbox"/> I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law   |

Your release of information authorization is valid to a maximum of three years from the date of this document. You may cancel this authorization at any time by written request, but the cancellation will not be retroactive. Signing this form does not waive non-disclosure rights.

\_\_\_\_\_  
SIGNATURE OF CLIENT OR GUARDIAN

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF AGENCY WITNESS

\_\_\_\_\_  
DATE