



## RELEASE OF INFORMATION

I, \_\_\_\_\_ (name of applicant/tenant), \_\_\_\_\_ (date of birth), authorize  
\_\_\_\_\_ (name of provider agency) to release the following information to  
RIHousing Section 811 program staff.

- Changes to service provider and/or case worker
- Length of hospitalization with anticipated discharge date if there is an extended absence from my unit

RIHousing and BHDDH Section 811 program staff are permitted to contact your service provider to verify whether or not you are actively engaged in supportive services and to determine your level of treatment (specify levels: ACT team, intensive outpatient, etc.)

This release does not authorize the service provider to disclose any information in violation of HIPPA such as but not limited to diagnosis and/or symptoms, medications, treatment plan, and/or case management notes.

This information may be used only for the purpose(s) of:

- ☐ Lease violations
- ☐ Recertification assistance
- ☐ Case conferences

I understand I have the right to this information at any time. I understand that I can revoke this consent in writing, at any time, to both the person giving and receiving the information.

This consent is valid for one year and will be renewed at my annual recertification.

\_\_\_\_\_  
Applicant/tenant

\_\_\_\_\_  
Date

Prohibition on re-disclosure: This information has been disclosed to you from records whose confidentiality is protected by law. Federal regulations **prohibit** further disclosure without specific written consent from the person to who it pertains.