

**SERVICE COORDINATION  
CONFIDENTIALITY AGREEMENT**

***Confidentiality is protection another person’s right to privacy***

In order for residents to have trust in their relationship with their service coordinator, it is important for residents to know that the information they reveal to the service coordinator will not be discussed with anyone else. This means that your personal information is not revealed to anyone, including staff or your family, without your written permission, unless required by law.

We utilize a “*Release of Information*” form to obtain this permission. As needed, the service coordinator will request that you complete and sign this form. The properly executed form will allow the service coordinator to discuss your service needs and desires with the specified community service providers, family members, physicians, and/or other individuals in order to link you to programs and services that will assist you in remaining self-sufficient.

***Exceptions to Right of Confidentiality***

Federal and/or state law may require me to disclose the following information:

- Adult Protective Services referrals: It may be necessary to report residents who are endangered or exploited.
- It may be necessary to disclose information pursuant to a proper court order.
- It may be necessary to report any information related to suspected fraudulent activity or other violations of law on your part.

Finally, as a condition of your participation in this housing program, you agreed in your lease that any employee or contractor, including service coordinators, has a responsibility to report lease violations to the property manager.

***Confidentiality Pledge***

As your service coordinator, I agree to protect your right to privacy and confidentiality. I will not disclose any information about you without your written permission unless I am required by law to do so.

\_\_\_\_\_  
Service Coordinator Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Resident Signature (OPTIONAL)

\_\_\_\_\_  
Date

***(Make a copy of this form to place in your file. Give the original signed copy to the resident)***

**RESIDENT SERVICE COORDINATOR  
CONSENT TO RELEASE OF INFORMATION**

Resident Name (First, Middle, Maiden, Last): \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I am presently a resident at: \_\_\_\_\_  
(NAME OF FACILITY)

I authorize the Service Coordinator (SC) at this "Facility to disclose the following information:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To the following person or organization:  
\_\_\_\_\_  
\_\_\_\_\_

The purpose of this disclosure is to:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Information obtained by the service coordinator will be maintained as confidential and released only to those employees who have a need to know such information, as required by law, or as provided in this Release. The service coordinator shall adhere to all applicable laws, regulations or professional license requirements.

I understand that I may revoke this Consent to Release of Information at any time by providing written or verbal notice of the revocation to the Service Coordinator. This revocation will not apply to information that has been previously released or action that has been taken in accordance with, and in reliance upon, this consent.

This consent (unless expressly revoked earlier) expires one hundred eighty days from the date indicated below.

Health information disclosed pursuant to this consent may be subject to redisclosure and would no longer be protected by 45 CFR Parts 160 and 164 unless applicable state law prohibits redisclosure of the information. Federal law prohibits redisclosure of substance abuse treatment information to any person without the written authorization in accordance with 42 CFR Part 2.

Signature of Resident: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Guardian, if applicable: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Resident: \_\_\_\_\_

Signature of SC : \_\_\_\_\_ Date: \_\_\_\_\_

**Report on Violations  
(Alleged or Otherwise)**

- \*Human or civil rights abuse
- \*Violations of personal property/dignity
- \*Adults abuse (mental/physical/financial)

Resident Name \_\_\_\_\_ Apt. # \_\_\_\_\_ Date \_\_\_\_\_

**REPORT:**

**ACTION TAKEN:**

**RESOLUTION:**

**NON-PARTICIPATION FORM**

I, \_\_\_\_\_, living at \_\_\_\_\_,  
(Name of Resident) (Name of Facility)

understand I am responsible for making my own decisions and choices regarding a service(s) available to me. At this time, I am refusing to use a service(s) available as presented by the Service Coordinator. The Service Coordinator has fully explained: the rationale for accepting a service(s); the specifics of the service(s) and; the possible consequences of refusing to participate in the service(s).

I hold the staff of \_\_\_\_\_  
(Name of Facility)

harmless in case of damage to my personal property or injury to my person caused by refusal to utilize the services of the Service Coordinator.

Conditions/Remarks:

Resident Signature \_\_\_\_\_ Date \_\_\_\_\_

Service Coordinator Signature \_\_\_\_\_ Date \_\_\_\_\_