

FILE #: \_\_\_\_\_

**RISE Disaster Case Management Consortium**  
**CONSENT TO THE RELEASE OF CONFIDENTIAL INFORMATION**

**INSTRUCTIONS**

Signing and returning this form authorizes **United Cerebral Palsy of Greater Houston** to share certain personal information collected about you or your family with other disaster relief and voluntary organizations participating in the Coordinated Assistance Network. **United Cerebral Palsy of Greater Houston** will collect this information in order to coordinate available disaster relief services and assistance and to reduce the paperwork and applications necessary in order for you or your family to receive disaster relief assistance and services from multiple relief organizations. All disaster relief organizations participating in the Coordinated Assistance Network are committed to respecting your privacy and using the information solely for the purpose of coordinating and providing disaster relief assistance.

With the exception of certain limited circumstances, it is the policy of **United Cerebral Palsy of Greater Houston** not to release information about individual or family disaster relief assistance, or other personal information obtained through the provision of disaster relief services, without the written consent of the individual or family. Therefore, we need your written consent to share this information and to assist you or your family with obtaining the disaster relief services in the most expeditious and least cumbersome manner.

**CONSENT AND RELEASE**

I, \_\_\_\_\_ *(Client Name)* \_\_\_\_\_, hereby authorize **United Cerebral Palsy of Greater Houston** to share any of my information in its possession, including but not limited to my name, address, other personal information and the type of assistance I am receiving with other disaster relief and voluntary organizations participating in the Coordinated Assistance Network in order to coordinate available disaster relief services and assistance.

If you wish to limit this release to specific information, please specify the information that may be released.

I understand that I may revoke this consent at anytime by contacting **United Cerebral Palsy of Greater Houston** except when action has already been taken to obtain and/or release such information to organizations participating in the Coordinated Assistance Network. My signature on this release indicates that I have read the above, or had it read to me, and that I understand the terms and conditions. I have also had the opportunity to ask any questions. I am also signing this release on behalf of my children that are under the age of eighteen (18).

\_\_\_\_\_  
Signature Head of Household Date

\_\_\_\_\_  
Signature Co-Applicant Date

**CONFIDENTIALITY AGREEMENT**

Any information provided by the client(s) to the Organization’s Staff or Volunteers is to be kept in the strictest of confidence. None of the information exchanged about donor individuals, donor organizations, or client cases will be discussed outside of the official interview and decision-making process of the Organization, except as authorized above.

\_\_\_\_\_  
Signature of Worker Date