



Pathways Community Network Client Authorization Form

I understand that _____ (this agency) is part of the Pathways Community Network, a computer network designed to reduce the amount of time and effort it takes for me to obtain the social services I need. This agency has my permission to:

1. Look at information about me in the Pathways system
2. Enter in the system information concerning my situation and need for assistance

I understand that:

1. Agencies in the Pathways system will keep this information confidential
2. Other agencies will be able to look at this information only if I give each of these agencies my permission
3. Staff at each agency receives regular training on client confidentiality and their legal responsibility to keep my information private
4. The Pathways system uses passwords and computerized codes to protect my privacy
5. Shared information may include my name, age, gender, marital status, veteran status, address, housing status, and basic information about my goals and the services I receive
6. I can obtain a copy of information about me collected by the Pathways system, except for psychotherapy notes and other information kept private by law

I also understand that I have the right to refuse to grant this authorization, and that even if I give permission for this agency to access my information in the Pathways system, I can revoke that permission at any time, without penalty.

I also understand that under certain circumstances, this agency or Pathways may be legally required to disclose some or all of my confidential information. This may happen if there is any evidence of child abuse, if there is evidence I may harm others or myself, or if a court orders that my information be disclosed.

The permission I am giving this agency to view my information and to place information about me in the Pathways system will expire on: _____ .

Signature: _____ Date: _____

Print Name: _____ ID: _____ Date of Birth: _____

Witness Signature: _____