



CRHMIS CLIENT REFUSAL OF HMIS DATA SUBMISSION

FOR ANY CLIENT OF CRHMIS-PARTICIPATING AGENCIES

The CRHMIS recognizes every independent legal adult (persons 18 years of age and older) as the owner of all information about themselves within the CRHMIS. Parents, legal guardians, and/or legal power of attorneys are the designated owners of all information about household members under their guardianship, which includes all minors (persons under 18 years of age) and any incapacitated/disabled adults.

All owners of information in the CRHMIS have the right to choose if information about themselves is entered into the CRHMIS, and the right to decide this at each participating project from which they receive services.

***By initialing below, I acknowledge that I understand and accept the provision in my refusal to participate in the CRHMIS:**

_____ I was given the option to have only information I was comfortable with entered into the CRHMIS

_____ I am NOT automatically ineligible for services

_____ I am NOT removed from the coordinated entry process

_____ I may still need to provide my personal information to the services provider

_____ I can request that my information be purged from the CRHMIS at any time (www.caresny.org)

_____ I can change my mind at any time and participate in the HMIS data collection at this or other service provider locations

***By signing this form, I confirm that I have read (or been read) this form, that I understand the information contained herein, and that I agree to all provisions herein. I also confirm that I refuse to allow my data, and that of any dependent household members under my guardianship (if any), to be entered into the CARES Regional HMIS (CRMIS) database at this time. I understand that this means I will not be participating in electronic referrals between participating agencies and may have to repeat the interview process at each provider.**

SIGNATURE of Client, Guardian, or Power of Attorney

SIGNATURE of Witness/Agency Worker

PRINT name

PRINT name

DATE

DATE

AGENCY NAME

PROJECT NAME

- Turn over to list dependent household members -



If you have further questions,
please contact CARES at (518) 489-4130.

Household members under your guardianship (if any) to which this form also applies:

	Name (First and Last)	Date of Birth (MM/DD/YYYY)
1		
2		
3		
4		
5		
6		