



PINELLAS HMIS CLIENT DELETION REQUEST

By signing below, I revoke my consent to share my Protected Personal Information (PPI) in the Pinellas HMIS.

I understand that this revocation authorizes the removal of my PPI from the shared HMIS database and will prevent further PPI from being added. I understand that the PPI that I previously authorized to be shared cannot be entirely removed from the HMIS database and will remain accessible to the limited number of organization(s) that provided me with direct services.

The Pinellas HMIS and Continuum of Care are hereby released from any legal responsibility or liability for the release, use or disclosure of information I authorized previously.

Client Name: _____ HMIS Client ID: _____

DOB: _____ Last 4 digits of SS _____

Client Signature: _____ Date: _____

Head of Household (Check only one) ____ Yes ____ No

Children of Client (if applicable):

Child's Name: _____ HMIS Client ID: _____

DOB: _____ Last 4 digits of SS _____

Child's Name: _____ HMIS Client ID: _____

DOB: _____ Last 4 digits of SS _____

Child's Name: _____ HMIS Client ID: _____

DOB: _____ Last 4 digits of SS _____

Name of Organization: _____

Organization Staff Name: _____

Organization Staff Signature: _____ Date: _____