



Confirmation Form  
for  
Consent to Rescind Participation in the  
Continuum of Care HMIS

A consent to Rescind Participation in the HMIS was received on \_\_\_\_\_ (mm/dd/yy) and I  
\_\_\_\_\_ (HMIS Coordinator) deleted the file with the below identifiers:

Last Name: \_\_\_\_\_  
First Name: \_\_\_\_\_  
Middle Initial: \_\_\_\_\_  
Other Name (s): \_\_\_\_\_  
Gender \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_

The file was deleted on \_\_\_\_\_ (mm/dd/yy) at \_\_\_\_\_ (CST) and information pertaining to this individual, accessible through the HMIS, is no longer available.