



Client Consent for Sharing of Your Information

By signing this form, you allow COHMIS partner agencies to share your personal information to coordinate housing and homelessness resources and related services on your behalf. Please read this form carefully and ask any questions you may have.

What is COHMIS?

COHMIS stands for the Colorado Homeless Management Information System. COHMIS is a system shared by partner agencies to store information about people who use homelessness services for purposes of providing better support for them. COHMIS is managed by the four Continuum of Care groups in the State of Colorado. They are MDHI (Metro Denver), Pikes Peak (El Paso County) Northern Colorado (Larimer and Weld Counties), and Balance of State (Remaining 54 Colorado Counties).

Who may share my information?

The partner agencies who are allowed to share your information include county human and social services agencies, non-profit community groups, and other care coordination groups that you are receiving, or may receive, services from. A current list of partner agencies is provided with this form and is available at <https://cohmis.zendesk.com/hc/en-us>.

How will my information be used?

The partner agencies may use your personal information for coordinating housing and homelessness resources and related services on your behalf. The Continuum of Care groups and partner agencies may use anonymous information (information that does not identify you) to do research, evaluate service programs, get funding, and for any other legal purposes related to the needs of the homeless community and people at risk of homelessness. The Continuum of Care groups and all partner agencies must keep your personal information confidential and follow all federal and state laws that apply to your information.

What information may be shared?

- Name, date of birth, gender, race, ethnicity, social security number, phone number, address
- Basic medical, mental health, substance use and daily living information
- Housing and program eligibility information
- Use of crisis services, veteran services, hospitals and jail
- Employment, income, insurance and benefits information
- Services provided by partner agencies
- Results from assessments
- Photograph or other likeness

BY SIGNING THIS FORM, I UNDERSTAND THAT:

- I have the right to know who has seen my information.
- I may see my information at any time and change it if it is wrong.
- I may cancel this consent at any time by filling out a revocation of consent form, which I can get from any partner agency.
- I may file a complaint if I think my information has been misused by filling out a grievance form, which I can get from any partner agency.
- I may refuse to share information with other agencies while retaining rights of access to this agency's services.
- If I refuse to share information, I may not be eligible to participate or receive services from some programs.
- I may have a copy of this form.
- This consent will expire seven years after this ROI is signed.

Printed Name of Client or Legal Guardian: _____

Printed Names of additional minor children covered by this release: _____

Signature of Client or Representative: _____ **Date:** _____

Signature of Agency Witness: _____ **Date:** _____

_____ *Initials of Client If Declining Consent*