



**CHAMP  
Non-HMIS Provider  
Authorization for Release of Information**

**Client Name (Printed):** \_\_\_\_\_

**HMIS Number:** \_\_\_\_\_

I hereby authorize the Knoxville/Knox County CHAMP Facilitator to disclose to \_\_\_\_\_ agency only the information, records, or portion of records to aid in coordination of care and movement within the CHAMP coordinated entry system. Information to be disclosed may include results from instruments used in the CHAMP process (e.g.: VI-SPDAT), placement and/or status on the Knoxville Community's By-Name Master List, and any other information that will facilitate the housing case management efforts of the non-HMIS partner agency within the CHAMP process.

This authorization automatically expires ninety (90) days from this date: \_\_\_\_\_ and is subject to revocation at any time, except to the extent that the program, facility, or individual which is to make the disclosure(s) has already acted in reliance on it.

\_\_\_\_\_  
Signature of Client or person authorized to consent  
for a minor or person unable to  
sign

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Name (Printed)

\_\_\_\_\_  
Relationship to client

\_\_\_\_\_  
Witness Signature