



# Nevada Ryan White Parts ABCD Common Guidance Document Universal Consent for Release of Confidential Information

Client Name \_\_\_\_\_

DOB: \_\_\_\_\_

I, the undersigned, do hereby authorize any of the agencies listed below who participate in the community based Ryan White All Parts (ABCD) Programs in the State of Nevada to release and/or share information concerning my eligibility, medical record status, and information concerning my HIV screening, diagnosis, and treatment. The following agencies/programs authorized are:

- |   |  |
|---|--|
| ❖ Access Community Cultural Education Programs & Trainings          | ❖ Medicare   |
| ❖ AIDS Healthcare Foundation  | ❖ Nevada AIDS Research & Education Society                         |
| ❖ Access to Healthcare Network                                      | ❖ Nevada Legal Services  |
| ❖ Aid for AIDS of Nevada  | ❖ Nevada Office of HIV/AIDS  |
| ❖ Care Coalition  | ❖ North County Healthcare  |
| ❖ OptumRx-Pharmacy Benefits Manager                                 | ❖ Northern Nevada HOPES  |
| ❖ Carson City Health and Human Services                             | ❖ Nye County Health & Human Services                               |
| ❖ Community Counseling Center                                       | ❖ Ridge House  |
| ❖ Community Outreach Medical Center                                 | ❖ Southern Nevada Health District                                  |
| ❖ Clark County Social Service                                       | ❖ The Gay & Lesbian Center of Southern Nevada                      |
| ❖ Dignity Health  | ❖ University Medical Center-Wellness Center                        |
| ❖ Division of Public and Behavioral Health HIV Surveillance Program | ❖ University Nevada, Las Vegas School of Community Health Sciences |
| ❖ Golden Rainbow  | ❖ UNLV School of Dental Medicine                                   |
| ❖ Horizon Ridge Clinic  | ❖ Washoe County Health District                                    |
| ❖ Las Vegas Urban League  | ❖ Your Health Insurance Company                                    |
| ❖ Nevada Medicaid   | ❖ Your Physician: _____  |

Information may be released between the above listed agencies throughout the duration of my active enrollment in the Ryan White All Parts (ABCD) program. I may withdraw this consent by notifying, in writing, the Ryan White agency where my eligibility was completed. I understand that my records are protected under federal HIPAA regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that I may revoke this consent in writing any time, except to the extent that any action has been taken while it is still in force. This consent expires automatically one (1) year from registration or previously signed consent.

A copy of this authorization legally constitutes an original copy.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature if under 18

\_\_\_\_\_  
Date

\_\_\_\_\_  
Registering Agency Staff Member

\_\_\_\_\_  
Date