Ryan White Parts A, B, C, and D in Nevada and the Las Vegas TGA

Consent for Release of Confidential Information-Affected Client

Affected Client's Name: _____ Date of Birth: _____ URN: _____

I, the undersigned, do hereby authorize any of the agencies listed below who participate in the community based Ryan White Care Services program 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 (ACCEPT)
- ❖ AIDS Healthcare Foundation
- ❖ Access to Healthcare Network (AHN)
- ❖ Aid for AIDS of Nevada (AFAN)
- ❖ Care Coalition
- ❖ Catamaran RX-Pharmacy Benefits Manager
- ❖ Carson City Health and Human Services
- ❖ Community Counseling Center (CCC)
- ❖ Community Outreach Medical Center (COMC)
- ❖ Clark County Social Service
- ❖ Dignity Health
- ❖ FirstMed Health and Wellness Center
- ❖ Golden Rainbow
- ❖ Horizon Ridge Clinic LLC
- ❖ Las Vegas Urban League
- ❖ Nevada AIDS Research & Education Society (NARES)
- ❖ Nevada Legal Services
- ❖ Nevada Office of HIV/AIDS
- ❖ North County Healthcare
- ❖ Northern Nevada HOPES
- ❖ Nye County Health & Human Services
- ❖ Ridge House
- ❖ Southern Nevada Health District (SNHD)
- ❖ The Gay & Lesbian Center of Southern Nevada (The Center)
- ❖ University Medical Center-Wellness Center (UMC)
- ❖ University Nevada Las Vegas (UNLV) School of Community Health Sciences
- ❖ UNLV School of Dental Medicine
- ❖ Washoe County Health District
- ❖ Women's Development Center (WDC)
- ❖ Your Physician:_____

Information may be released between the above listed agencies throughout the duration of my active enrollment in the Ryan White Care Services 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.

_____	_____
Affected Client's Signature (Required for persons over 18)	Date
_____	_____
Client Signature	Date
_____	_____
Parent or Guardian/ Relationship to Client	Date
_____	_____
Witness	Date

I understand that, by signing this release, I am allowing _____ to seek
Affected Client's Name

services and discuss issues concerning my service related information only, to assist in my -_____-
Client's Name
care. I also understand that I may revoke this consent in writing at any time.

I am withdrawing this consent for release of information.

_____	_____	_____
Signature of Client	Relationship	Date