Authorization for disclosure of Protected Health Information

SECTION I

Client Name ______________________________Client Birth Date ___________________________

As the person signing this authorization, I understand that I am giving permission to ______________________________ to disclose personal health information to the person(s) or organization(s) I have indicated.

- I understand the provision of treatment to me cannot be conditioned on my signing of this authorization.
- Any health information redisclosed by you will no longer be protected by this authorization.
- The original or a copy of this authorization shall be included with my medical record.
- I have the right to revoke this authorization at any time, except to the extent that action has been taken prior to my request to withhold my medical record. The request must be in writing and will be effective upon delivery to the provider in possession of my medical records.
- I authorize ___________________________ to disclose my health information to the following organization(s) or person(s):

Beginning date	Ending date	Organization/person	Purpose for disclosure	Information to be disclosed

This information may be disclosed immediately

SECTION II

I want the following confidential information about the client/I to be exchanged (check all that apply)

☐ Ryan White HRSA Required Variables
☐ Assessment Information
☐ Financial Information
☐ Benefits/services needed/received
☐ Family History
☐ Medical Diagnosis
☐ Mental health Diagnosis
☐ Medical Records
☐ Household Information
☐ Psychological Records
☐ Educational Records
☐ Psychiatric Records
☐ Criminal Justice Records
☐ Employment Records

Other information (write in): _________________________________

I want this information to be exchanged ONLY for the following purpose(s):

☐ Service Coordination and Treatment planning
☐ Eligibility Determination
☐ VDH and HRSA reporting requirements

I want information to be shared via:

☐ Written Information
☐ In meeting or by phone
☐ Secured Centralized Database, accessed only by Ryan White providers

SECTION III

I understand and have been informed that some or all of my treatment costs will be paid for through The Ryan White Care Act. I further understand that Virginia is a Client Demonstration Site (CDP) and that data from the CDP will be reported to HRSA to contribute to information abut clients who receive care, about services provided to Ryan White Care Act-funded clients, and about the health outcomes of these clients. I understand that at no time will any identifying information about myself, such as name address ever be reported. I understand that Federal and State confidentiality laws and regulations protect my records.

____________ Client Initial

I understand that under The Ryan White Care Act, my records are subject to "Peer Review". The Peer Review Committee is composed of medical and social service professionals chosen annually by each consortia or EMA grantee. Each panelist must sign a confidentiality agreement. Case records are chosen at random for review. Reviewers have no personal or professional interest in knowing the identity of the recipients of services provided under The Ryan White Care Act. Reviewers are only interested in the quality of service provided by each funded service provider.

_____________Client Initial

I understand that data about this client will be exchanged with other participating Ryan White Care Act funded service agencies in my service area that provide services to this client.

_____________Client Initial

I would like you to discuss my health information with the following individuals acting as my personal care representative. Name ______________________________________

I prefer that you contact me in a way other than my address or my phone number. I wish to be contacted in the following manner:

____

____

____

____

Please Print Name

______________________________ ______________

Signature **Date**

If signing on behalf of the patient:

____

Please Print Name

______________________________ ______________

Signature **Date**

*******This form must be filed in the record***
*******A copy of this authorization is available to the client upon request***