

# Ryan White Part A Consent for Release of Confidential Information



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 Las Vegas Tgansitional Grant Area (TGA) 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 to Healthcare              | ❖ Golden Rainbow                            |
| ❖ Aid for AIDS of Nevada (AFAN)     | ❖ Mohave County Health Department           |
| ❖ Community Counseling Center       | ❖ Nye County Health & Human Services        |
| ❖ Community Outreach Medical Center | ❖ Southern Nevada Health District           |
| ❖ Clark County Social Services      | ❖ University Medical Center-Wellness Center |

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 Part A 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  
- \_\_\_\_\_-care. I also understand that I may revoke this consent in writing at any time.  
Client's Name

I am withdrawing this consent for release of information.

Signature of Client	Date
Relationship	Date