

## Ryan White Part A Consent for Release of Confidential Information

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
- ❖ Aid for AIDS of Nevada (AFAN)
- ❖ Community Counseling Center
- ❖ Community Outreach Medical Center
- ❖ Clark County Social Services
- ❖ Golden Rainbow
- ❖ Mohave County Health Department
- ❖ Nye County Health & Human Services
- ❖ Southern Nevada Health District
- ❖ University Medical Center-Wellness Center
- ❖ 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 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.

\_\_\_\_\_  
Client's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Guardian/ Relationship to Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date