AUTHORIZATION TO EXCHANGE / RELEASE CONFIDENTIAL INFORMATION

SECTION I: Demographics - *I understand that different agencies provide different services and benefits, and that each agency must have specific information in order to do so. By signing this form, I am giving permission for the agencies below to exchange/ release information so that they can work effectively together to provide/coordinate services and benefits on my behalf.*

_____

Full name, printed | Social Security Number | Date of Birth (month/day/year)

_____

Address | City | State | Zip Code

My relationship to the client is: _X_Self __Parent __Power of Attorney __Guardian __Other Authorized Representative

SECTION II: Release of Records - *I wish to exchange the following confidential information (check all that apply):*

- ☑ RW HRSA Required Data Elements
- ☑ Family History
- ☑ Psychiatric Records
- ☑ Household Information
- ☑ Assessment Information
- ☑ Financial Information
- ☑ Employment Records
- ☑ Laboratory Test Results
- ☑ Medical Diagnosis & Records
- ☑ Mental Health Diagnosis & Records
- ☑ Criminal Justice Records
- ☑ Substance Abuse/Addiction
- ☑ Personal Contact Info.
- ☑ Medications
- ☑ Other medications _____

SECTION III: Information to Coordinate Care and Benefits - *I wish to exchange the specified information with the following person(s) or agencies (check all that apply):*

- ☑ Alexandria Health Department
- ☑ Arlington Health Department
- ☑ ARE (AIDS Response Effort)
- ☑ AIDS Drug Assistance Program
- ☑ AIDS Healthcare Foundation
- ☑ FAHASS (Fredericksburg Area HIV/AIDS Support Services)
- ☑ Fairfax Health Department
- ☑ INOVA Juniper Program
- ☑ INOVA Hospitals/Healthcare Facilities
- ☑ IPHI (Institute for Public Health Innovation)
- ☑ Infectious Diseases Physicians
- ☑ Kaiser Permanante
- ☑ Legal Services of NOVA
- ☑ La Clinica Del Pueblo-DC
- ☑ LabCorp Laboratory
- ☑ Loudoun Health Department
- ☑ Mary Washington Healthcare
- ☑ Neighborhood Health/ Casey Clinic
- ☑ National Institutes of Health
- ☑ Northern VA Family Services
- ☑ NOVA Salud, Inc.
- ☑ Northern Virginia AIDS Ministry
- ☑ Northern Virginia Regional Commission
- ☑ Prince William Health Department
- ☑ University of Virginia (UVA)
- ☑ Virginia Department of Health
- ☑ Virginia Health Options-VHO
- ☑ Virginia Hospital Center
- ☑ Other Agencies/ Individuals (specify)
- ☑ Freddy Zambrano _____
- ☑ _____
- ☑ _____
- _____

SECTION IV: Signature Authorization - This information is released with the understanding that I may revoke this authorization at any time except to the extent that the person or entity authorized to release this information has already acted in reliance on it. I have hereby reviewed this consent form and deem it valid for up to two years.

_____

Client, Parent or Authorized Signature | Date | Agency Staff Person_____

SECTION V: Staying Connected to Care - In the event that I lose contact with NOVA Salud for 6 months or longer, I hereby give the agency permission to make all reasonable efforts to contact me for up to 1 year after my last date of contact. *I understand that these efforts may include an exchange of my personal and medical information between participating Ryan White CARE Act*

funded providers. I also understand that this exchange of information is strictly to ensure that my client care and support service needs are continually met, and will not be used for any other purposes.

_____

Client, Parent or Authorized Signature Date Agency Staff Person

SECTION VI: Withdrawal of Consent - *I understand that I may refuse to sign this form and that my refusal to sign will not affect my ability to obtain treatment or to enroll in services.*

_____

Client, Parent or Authorized Signature Date Agency Staff Person

CONSENT TO RECEIVE SERVICES

SECTION I: Consent to Receive Services - *I understand or have been informed that some or all of my treatment and/or services costs will be paid for through the Ryan White CARE Act and /or through HOPWA (Housing Opportunities for Persons with AIDS) programs.*

_____

Client, Parent or Authorized Signature Date Agency Staff Person

SECTION II: Information for Reports and Statistics

If I receive Ryan White or HOPWA services from this individual or agency, my name and financial, household and benefits/services information will be stored in a secure database. My records may be reviewed by

1. Federal funding agencies and/or their representatives; and/or by
2. Other Ryan White and/or HOPWA service providers to insure that only one client record is created for each services user.

I understand or have been informed that federally funded agencies are expected to review the quality of services provided.

_____

Client, Parent or Authorized Signature Date Agency Staff Person

SECTION III: Quality Management - *I understand that my information may be reviewed to help guarantee/insure the quality of the services I receive are the best possible.*

_____

Client, Parent or Authorized Signature Date Agency Staff Person