Alabama Ryan White HIV/AIDS Part B Program
Authorization for Release of Protected Health Information

Client's name_____ SS#_____ DOB_____

Street Address_____ City_____ State_____ County_____

Zip_____ Telephone # _____

I HEREBY AUTHORIZE:

Alabama Department of Public Health (ADPH)
The RSA Tower
201 Monroe Street
Montgomery, AL 36104

and/or

Ryan White HIV/AIDS Provider:
_____
_____
_____

TO RELEASE, TO RECEIVE, AND/OR DISCUSS THE INFORMATION DECRIBED BELOW TO:

United Way of Central Alabama, Inc. (UWCA)*
3600 8th Avenue South
Birmingham, AL 35222

Alabama Partners in Care (APIC)
ADPH, UWCA, and other Ryan White Program providers and participants

*UWCA serves as Alabama's Ryan White HIV/AIDS Program Part B Lead Agency and insurance benefits manager.

MY AUTHORIZATION IS FOR THE USE AND DISCLOSURE OF THE FOLLOWING RECORDS:

Medical information and appointments, including treatment; supportive service appointments and history; individual/household financial information; service referrals; and any other healthcare/eligibility information related to my eligibility or enrollment in and services provided or funded by Alabama's Ryan White HIV/AIDS Part B Program.

THE PURPOSE FOR THE USE OR DISCLOSURE OF THIS INFORMATION IS TO:

Enable the administration of Alabama's Ryan White HIV/AIDS Part B Program, which may include providing funds to my medical and supportive service providers, sharing eligibility information within Alabama's statewide network of APIC Ryan White providers, analysis and reporting pursuant to federal grant requirements, and coordination of care and benefits.

MY AUTHORIZATION IS GIVEN FREELY WITH THE UNDERSTANDING THAT:

*I may revoke this authorization at any time, except where information has already been released in reliance on my authorization, provided that my revocation is in writing and given to the parties authorized to use or disclose information at the address(es) above;
*Ryan White HIV/AIDS providers may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization;
*A photocopy or fax of this authorization is as valid as the original;
*The information to be disclosed may be subject to re-disclosure by the recipient pursuant to State of Alabama and Federal rules and regulations and may no longer be protected by federal privacy regulations;
*Agreements are in place between ADPH, UWCA, my Ryan White Provider, and Alabama's network of Ryan White providers (APIC members) to protect re-disclosure and/or unauthorized use of healthcare, medical, and client information;
*This authorization is valid for 15 consecutive months from the date of my signature unless I revoke it earlier and to be completed during each annual (birth month) eligibility certification;
*Information used or disclosed pursuant to this Authorization will not be sold or otherwise used for profit or gain;
*I will be given a copy of this signed authorization upon request from my Ryan White HIV/AIDS provider.

CLIENT (or CAREGIVER) SIGNATURE_____ DATE_____

PRINT OF ABOVE SIGNATURE _____

RELATIONSHIP OF CAREGIVER TO CLIENT (if applicable) _____

WITNESS SIGNATURE_____ DATE_____

PRINT OF ABOVE SIGNATURE _____