Ryan White CARE ACT Program

Authorization to Release and Share Information

Name:
Social Security Number:
Date of Birth:

Purpose: I understand that my records are protected by data privacy rules. I understand I have the right to refuse to sign this consent. I understand if I sign, I am giving permission to all my case managers to share information about me. They will share information only to the extent that is necessary for my case management.

What happens if I don't sign this form? My case management plans may not be coordinated.

I authorize the Sioux Falls Health Department Ryan White Part C Program and its employees to receive from and share information with:

Initial

☐ ____ South Dakota Ryan White Part B CARE ACT Program, Department of Health, 615 East Fourth Street, Pierre, SD 57501

☐ ____ Tri-State Help (HOPWA), Sioux Falls Housing, 630 South Minnesota Avenue, Sioux Falls, SD 57104

☐ ____ Heartland Health/Part B CARE ACT Program, 2500 West 49th Street, Suite 103, Sioux Falls, SD 57105

☐ ____ Emergency Contact

☐ ____ Miscellaneous Agency

The information will be shared: orally (conversation with contact person), in writing, or both.

I am aware that my case file information is confidential and will be used by the above for my care coordination. I may cancel this release in writing at any time, except to the extent action was already taken on it. This consent automatically expires upon termination from the Ryan White Part C Program. A photocopy of this signed authorization shall be as valid as the original.

_____ _____

Ryan White Client Signature Date

_____ _____

Witness Date