CENTRAL OHIO
HIV CASE MANAGEMENT NETWORK
RELEASE FORM

I, _____, (DOB_____) authorize appropriate staff and/or volunteers of the following Ryan White funded agencies:

- Equitas Health
- Southeast, Inc.
- Columbus Public Health
- Ohio Department of Health
- Nationwide Children's Hospital
- Ohio State University Wexner Medical Center
- AIDS Healthcare Foundation

to release/share information regarding services I have received, my HIV status, my physical, financial, chemical dependency, and/or mental health conditions, among those same agencies for the express purpose of receiving or gaining access to all services related to my current or future needs. I understand that information regarding the above will be maintained in electronic data management systems. These systems have been explained to me, and I grant permission for them to be utilized to provide services for me.

This consent may be revoked at any time in writing or by informing the agency holding the original form; except to the extent that action has already occurred in reliance thereupon. I understand that I may add other specific agencies to this form by listing and signing below. I understand that this authorization for the release of information will automatically expire 365 or _____days after the date on the release, unless otherwise indicated below.

Date of expiration _____Reason and date of Earlier Expiration_____

_____ _____
Client's Signature Date

_____ _____
Agency Representative's Signature Date

<u>Prohibition Against Re-Disclosure:</u> This information has been disclosed to you from records protected by Federal confidentiality rules. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client. (These conditions apply to every page disclosed and a copy of this authorization will accompany every disclosure.) Any information regarding an individual's HIV test, AIDS diagnosis, or AIDS-related condition has been disclosed to you from confidential records protected from disclosure by state law. You are not authorized to disclose this information without the specific, written, and informed release of the individual to whom it pertains, or as otherwise permitted by state law. Please note that a general authorization for the release of medical or other information, as signed by the patient, is not sufficient for the release of the HIV test results or diagnosis.