# Central Ohio HIV Housing Network Release Form

I, _____, (DOB _____) authorize appropriate staff of the following Ryan White and/or Housing Opportunities for Persons with AIDS (HOPWA) funded agencies (check all that apply):

- ☐ AIDS Healthcare Foundation
- ☐ Columbus Public Health – Part A
- ☐ Equitas Health
- ☐ FACES Clinic at Nationwide Children's Hospital
- ☐ Lancaster Fairfield Community Action Agency
- ☐ Southeast, Inc.

To release/share information regarding services I have received, my HIV status, my financial situation and housing status, among those same agencies for the purpose of determining eligibility for Ryan White Part A and/or HOPWA housing services related to my current or future needs. I understand that information regarding the above may 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. Furthermore, I understand the agencies named above may communicate with one another regarding housing services that may be available to me in order for the most appropriate service to be accessed.

No agency above may condition treatment or enrollment in housing services on whether the client or guardian signs this form.

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 after ONE YEAR or _____ days after the date on this release, unless otherwise indicated below.

Date of expiration _____. Reason and date of earlier expiration _____

_____ _____

***Client or Guardian's Signature*** ***Date***

_____ _____

***Agency Representative's Signature*** ***Date***

**Client has a right to receive a copy of this authorization upon request.**

***Prohibition Against Re-Disclosure:*** *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.*