Nevada Ryan White Parts ABCD
Common Guidance Document
Universal Consent for Release of Confidential Information

Client Name: _____ DOB: _____

I, the undersigned, do hereby authorize any of the agencies listed below who participate in the community based Ryan White All Parts (ABCD) Programs in the State of Nevada to release and/or share information concerning my eligibility, medical record status, and information concerning my HIV screening, diagnosis, and treatment. The following agencies/programs authorized are:

- ❖ Access Community Cultural Education Programs & Trainings
- ❖ AIDS Healthcare Foundation
- ❖ Access to Healthcare Network
- ❖ Aid for AIDS of Nevada
- ❖ OptumRx-Pharmacy Benefits Manager
- ❖ Carson City Health and Human Services
- ❖ Community Counseling Center
- ❖ Community Outreach Medical Center
- ❖ Clark County Social Service
- ❖ Dignity Health
- ❖ Division of Public and Behavioral Health HIV Surveillance Program
- ❖ Golden Rainbow
- ❖ HELP of Southern Nevada
- ❖ Horizon Ridge Clinic
- ❖ Huntridge Family Clinic
- ❖ Las Vegas Urban League
- ❖ Nevada Medicaid
- ❖ Medicare
- ❖ Nevada AIDS Research & Education Society
- ❖ Nevada Legal Services
- ❖ Nevada Office of HIV/AIDS
- ❖ North County Healthcare
- ❖ Northern Nevada HOPES
- ❖ Nye County Health & Human Services
- ❖ Ramsell Corp. – Pharmacy Benefits Manager
- ❖ Southern Nevada Health District
- ❖ The Gay & Lesbian Center of Southern Nevada
- ❖ University Medical Center-Wellness Center
- ❖ University Nevada, Las Vegas - College of Medicine - Maternal and Child Wellness Program
- ❖ University Nevada, Las Vegas School of Dental Medicine
- ❖ Washoe County Health District
- ❖ Your Health Insurance Company
- ❖ Your Physician: _____
- ❖ Partner/Spouse/Other: _____

Information may be released between the above listed agencies throughout the duration of my active enrollment in the Ryan White All Parts (ABCD) program. I may withdraw this consent by notifying, in writing, the Ryan White agency where my eligibility was completed. I understand that my records are protected under federal HIPAA regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that I may revoke this consent in writing any time, except to the extent that any action has been taken while it is still in force. This consent expires automatically one (1) year from registration or previously signed consent.

A copy of this authorization legally constitutes an original copy.

Client Signature	Date
Parent/Guardian Signature if under 18	Date
Registering Agency Staff Member	Date