



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

Client Name: _____

DOB: _____

I 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:

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

Client Signature

Date

Parent/Guardian Signature if under 18

Date