ILLINOIS Department of Public Health **Authorization for Release of Health Information**

Ryan White Part B Program

First Name	Middle Initial	Last Name

Social Security Number (Leave blank if no valid SS number for client)	Date of Birth (mm/dd/yyyy)
	/ /

Please read all statements and sign in the space provided to certify that you have read and understand this authorization. All references to "Program" or "Programs" refers to the Illinois Department of Public Health, Ryan White Part B Program and/or successor programs in which you participate or to which you apply for services.

1. I certify that the information in this application is true and accurate to the best of my knowledge. I understand that I may be disqualified from this program(s) and/or prosecuted for willfully providing false information.
2. I understand that the information requested on this application is for the purpose of determining my eligibility for a state and federally funded program. The funding is limited and may expire at any time without extended or alternate funds being available.
3. If I am considered eligible for services, my information will be utilized with our contractual partners for the reasons explained in this document. Eligibility approval does not mean I will receive or be enrolled in all services. I understand each service may require additional information, and that I must provide this information for verification before enrollment into said services.
4. Upon approval, my eligibility will expire after six months. Upon the conclusion of my six months, I will be required to reapply and provide updated eligibility information to continue accessing services. I agree to submit periodic information regarding my continued eligibility for participation in the program(s), including proof of income, proof of residency, availability of health insurance coverage, and an updated and signed version of this form with my Recertification Application every (6 months) as per Federal Guidelines.
5. I agree to notify, or to have my Medical Case Manager notify the program(s) of any circumstances affecting my participation in, or eligibility for, the program(s). I agree to notify the program(s) within thirty (30) days of a change in address and understand that all program correspondence will be sent to the address I have on file with the program(s). I understand changes in my situation will be periodically evaluated to determine continued eligibility for the program(s).
6. I authorize the program to release my enrollment, eligibility and service utilization records and other information necessary to facilitate the provision of program services to my physicians, other providers, treatment centers, pharmacy benefit managers, third party administrators, health insurers, or entities that are under contract with the program with the understanding that my status will never be disclosed to entities not affiliated with the Ryan White Part B Program in the bullet point list below.
7. If I experience discrimination because of the release or disclosure of medical related information, I may contact the Illinois Department of Human Rights at (217) 785-5100 or (312) 814-6200. This agency is responsible for enforcing the Illinois Human Rights Act which provides certain protections for persons with disabilities.
8. If I request enrollment into Medical Case Management or request any service that requires coordination with a Medical Case Manager, my information will be shared with the Medical Case Management provider that the Care Connect Regional Lead Agent who is administering this program in my area assigns to me.
9. I acknowledge that my health insurance premiums (if applicable) are being paid by the program via a contractual third party payer source. In consideration of same, I hereby authorize and direct my health insurer to directly reimburse the IDPH for any unused premium payments should my insurance policy terminate or be cancelled for any reason, including but not limited to future ineligibility, death, voluntary termination, involuntary cancellation, or termination by operation of law.
10. I agree to indemnify and hold the Illinois Department of Public Health (IDPH) harmless from any and all claims for making premium reimbursement payments directly to the IDPH or any entity under contract with the IDPH in connection with Program Services. I agree to indemnify and hold the IDPH, or any entity under contract with the IDPH in connection with Program Services, harmless from any and all claims for receiving premium reimbursement payments directly from IDPH or my health insurer. This agreement shall be binding on my administrators, executors, heirs, successors and assigns and shall remain in full force and effect during the time period in which I am enrolled in the Program(s).
11. I agree to reimburse IDPH for any and all premium reimbursement payments that are paid to me in error during my enrollment.
12. I understand that my records are protected under the Health Insurance Portability and Accountability Act, Pub.L 104-491, 110 Stat. 1936, enacted August 21, 1996, and Illinois Statute 410 ILCS 305 relating to confidentiality of medical information, and cannot be disclosed to any other entity except those referenced herein without my written consent. I do not have to consent to the release of this information. However, if I refuse to sign this authorization, I will be ineligible to receive services through this program.
13. I understand that I may revoke this authorization at any time in writing. However, the release shall remain valid for a period of **24 months** from the date this form is signed, or until such time as I inform the administrator of the Program(s), in writing, of my wish to terminate services in the Program(s). I also understand that I will still be required to sign a new authorization form every 6 months to continue Ryan White Services. I also

understand that each time I sign a new reauthorize on a 6 month basis for renewal purposes that any and all previous authorization(s) become null and void.

a. This authorization refers to authorizing the release for a validity period spanning 24 month period from the date this form is signed for those instances when I may step away from care after a 6 month certification, which this authorization will provide permission for reengagement activities to take place by designee(s) of the Department not to exceed the 24 months from the date of signature.

The agencies listed below are utilized to coordinate and verify eligibility for all services, and for treatment and care coordination with other program(s) within IDPH, following the same confidentiality requirements identified above in statements 1-13:

- System Software Vendor *
- Premium Assistance Payment Vendor*
- Pharmacy Benefits Manager Vendor*
- Quality Assurance & Compliance Vendor*
- Centers for Medicare & Medicaid Services
- IL Department of Insurance
- DIS Outreach Specialists employed by IDPH and/or local Health Departments
- Chicago Department of Public Health
- IL Department of Employment Security (Income Verification Services)
- IL Department of Health and Family Services (Medicaid Verification Services)
- IL Department of Public Health programs per Illinois Statute 410 ILCS 305
- IL Department of Public Health's Office of Health Protection Sections/Programs
- All Ryan White funded Providers

* Specific vendor information can be requested at: https://www.wh1.ioc.state.il.us

With my signature, I authorize IDPH and its subcontracted providers to contact the Alternate Contact listed below, and understand that I will be required to list this contact on each submission of this form.

____

Alternate Contact Person Name **(You do not have to list your Case Manager)**

____

Street Address

____

City State Zip Code

(_________) ___________ - _______________ Is this person aware of your + status? ☐ Yes ☐ No

Telephone

With my signature, I authorize IDPH and its subcontracted providers to contact the Alternate Contact listed below, and understand that I will be required to list this contact on each submission of this form.

____

Alternate Contact Person Name **(You do not have to list your Case Manager)**

____

Street Address

____

City State Zip Code

(_________) ___________ - _______________ Is this person aware of your + status? ☐ Yes ☐ No

Telephone

____ / /

Client Signature (age 12 and older) **Date**

____ / /

Parent/Guardian (if under 12) or Legal Representative **Date**

PLEASE RETURN THIS PAGE