Ryan White CARE ACT Program

Authorization to Release and Share Information

Name:
Social Security Number:
Date of Birth:

Purpose: I understand that my records are protected by data privacy rules. I understand I have the right to refuse to sign this consent. I understand if I sign, I am giving permission to all my workers to share information about me. They will share information only to the extent that is necessary for my case management.

What happens if I don't sign this form? My case management plans may not be coordinated.

I authorize the Sioux Falls Health Department Ryan White Part C Program and its employees to receive from and share information with:

South Dakota Ryan White Part B CARE ACT Program
Department of Health
615 East Fourth Street
Pierre, SD 57501
605-773-3737 or instate 1-800-592-1861

South Dakota Ryan White Part B CARE ACT Program
6709 South Minnesota Avenue, Suite 102
Sioux Falls, SD 57108
605-322-7258

Tri-State Help (HOPWA)
Sioux Falls Housing
630 South Minnesota Avenue
Sioux Falls, SD 57104

The information will be shared: orally (conversation with contact person), in writing, or both.

I am aware that my case file information is confidential and will be used by the above for my care coordination. I may cancel this release in writing at any time, except to the extent action was already taken on it. This consent automatically expires one year from the date I sign it. A photocopy of this signed authorization shall be as valid as the original.

_____ _____
Ryan White Client Signature Date

_____ _____
Witness Date