



**Release of Information**

I, \_\_\_\_\_ (*Client Name*), authorize Care Directions, Arizona School of Dentistry and Oral Health, Chicanos Por La Causa, Maricopa County Employee Benefits and Health, Ebony House, Maricopa Integrated Health System, Maricopa County Office of Health Education & Promotion, Phoenix Indian Medical Center, Southwest Center for HIV/AIDS and Sun Life, Ryan White HIV/AIDS Program Grantees and/or Contractors, to disclose my protected health information (PHI) and other information from my records to any Ryan White HIV/AIDS Program (Ryan White) Grantee or Contractor operating in Maricopa County and/or Pinal County, Arizona.

The purpose of the disclosure is to permit Ryan White HIV/AIDS Program Grantees and/or Contractors to exchange my PHI or other information from my records to Ryan White Contractors and Grantees for the purposes of:

- Continuity of care, treatment, payment, and health care operations, including eligibility, demographic, emergency treatment, payments to Contractors or other statistical reporting information;
- Mandated reporting, including client-level data reporting;
- Disclosures required by law;
- Legal process and proceedings;
- Oversight including quality assurance reviews and audits of Ryan White-funded services provided;
- Disclosure to a Medical Examiner;
- Disclosure of notifiable public health conditions; and
- Inclusion in shared data systems for demographic, eligibility, and other statistical reporting;
- If in the course of providing services to a client, a RWPA provider identifies information that could be harmful to the client or the public; the provider may report that information to the appropriate authorities.

If required for the purposes listed above, I authorize the disclosure of the following information for the period of time from the date of my signature to one (1) year from the date of my signature:

- HIV/AIDS and other communicable disease information, including HIV Counseling and Testing;
- Behavioral, Mental Health or Psychiatric treatment information; and/or
- Substance abuse treatment information.

Unless I revoke this authorization earlier, it will expire one (1) year from the date of my signature. I also understand that my revocation will not apply to information that has already been released in response to this Release. To revoke this authorization, I must submit a written request to

Central Eligibility Office, Care Directions  
1366 E. Thomas Road, Suite 203  
Phoenix, AZ 85014

By signing this Release of Information, I release all Ryan White Grantees and Contractors, their employees, officers, directors, medical staff, and agents from any legal responsibility or liability for the disclosure of information to the extent indicated and authorized in this Release. I also understand that Ryan White Grantees and Contractors will maintain the confidentiality of my disclosed PHI or other information, and that they will use my PHI or other information only for the purposes listed above.

I understand the matters discussed on this Release of Information and that by signing below, I acknowledge that I have received a copy of the Ryan White Program Notice of Privacy Practices, Provider List, and Statement of Client Rights and Responsibilities, along with the HIV Care Directions' Client Grievance Policy.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Legal Representative

\_\_\_\_\_  
Relationship to Client