ILLINOIS Department of Public Health
Ryan White Part B Program

Authorization for Release of Health Information

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 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 12 months. Upon the conclusion of my twelve 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, 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, the program of any circumstances affecting my participation in, or eligibility for, the program. I agree to notify the program 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. I understand changes in my situation will be periodically evaluated to determine continued eligibility for the program.

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 any entity under contract with the program.

7. 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 AIDS Confidentiality Act, 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.

8. I understand that I may revoke this authorization at any time in writing. However, the release shall remain valid for a period of **12 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), except to the extent that action has been taken in reliance on this authorization.

The Contractual agencies listed below are utilized to coordinate and verify eligibility for all services, with the same confidentiality requirements identified above in statements 1-8 followed:

- System Software Vendor
- Pharmacy Benefits Manager Vendor
- Quality Assurance & Compliance Vendor
- Centers for Medicare & Medicaid Services
- IL Department of Insurance
- IL Department of Health and Family Services - (Medicaid verification)

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 Person listed below, and understand that I will be required to list this contact on each submission of this form. IF YOU WILL NOT BE PROVIDING A CONTACT, PLEASE "X" OUT THIS BOX.

_____
Alternate Contact Person Name

_____
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**

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
RYAN WHITE PART B AUTHORIZATION OF ENROLLMENT

Addendum for Additional Contacts

(This page required ONLY if additional contacts are listed)

With my signature, I authorize IDPH and its subcontracted providers to contact the Alternate Contact Person listed below, and understand that I will be required to list this contact on each submission of this form. IF YOU WILL NOT BE PROVIDING A CONTACT, PLEASE "X" OUT THIS BOX.

Alternate Contact Person Name

Street Address

City State Zip Code

(________) __________ - ______________ Is this person aware of your + status? ☐ Yes ☐ No
Telephone

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Telephone

/ /

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

/ /

Parent/Guardian (if under 12) or Legal Representative

ANY ALTERATION TO THIS DOCUMENT IS CONSIDERED FRAUDEULENT AND ILLEGAL