ND RYAN WHITE PROGRAM PART B RELEASE OF INFORMATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DISEASE CONTROL AND FORENSIC PATHOLOGY
SFN 62373 (7-2023)

Client's Name	RW Number	Agency

I, _____, authorize ND Ryan White Program staff or their agents to discuss my case and diagnosis (if necessary) with the providers listed to obtain and maintain services that I may qualify for:

HIV/primary care provider and clinic staff	Other medical care providers (pharmacist, dentist, etc.)
County human service worker	ND Medicaid representative
Insurance enrollment assisters	Insurance providers
Ryan White program staff	Housing assistance coordinator
Social worker	Peer navigators or advocates
Other:	

I also authorize ND Ryan White program to check with private insurers and employers about health or dental insurance I may have. This authorization is for the sole purpose of obtaining eligibility information dates and premium information in order to assist with insurance premiums and ensure appropriate health coverage.

This permission will expire one year from the date of my signature. I may revoke this authorization at any time by writing to the ND Ryan White Program. If I revoke this authorization, ND Ryan White Program staff and the persons indicated above may act on the information that has been released up to the date of that revoke.

I understand that information about me is protected by state and federal privacy laws. I understand that this information cannot be released without my consent, except as provided by law.

I understand that I do not have to sign this authorization form. If I choose not to sign this form, it may limit or curtail the services that may be offered to me. If I sign this form, I have the right to receive of a copy of the completed authorization.

Client/Guardian Signature	Date
Case Manager Signature	Date