

CONSENTS AND SIGNATURES

I give my permission for VDH to obtain, verify, and/or release my race, ethnicity, address, medical, prescription, and/or insurance coverage information, with other agencies as necessary to manage my medication access and services through the Virginia Ryan White Part B program including the Virginia Medication Assistance Program (Ryan White Part B Program). VDH may share my information with, but not limited to: physicians, health department personnel, case managers, other Division of Disease Prevention programs (including HIV Surveillance, HIV Care, and HIV Prevention), treatment center personnel, pharmacy services providers, referral sources for services or agencies, clinics, insurance broker, agencies that pay my insurance premiums or medication copayments, and/or insurance carrier. VDH and these entities agree to treat any and all such information as confidential.

I give permission for VDH to release records or information to necessary agencies to support the application or payment by Medicare, Medicaid, other health care benefits, or services through the Ryan White Part B Program. ☐ Yes ☐ No

I have read (or had read to me) the information and permissions. I understand this information and my signature shows my agreement with these conditions for services from the Ryan White Part B Program. I have verified that the information provided in this application is complete and accurate to the best of my knowledge.

Printed Client Name: _____

Client's Signature: _____

Date: _____

Client Responsibilities, Understandings, and Rights

- It is my responsibility to provide information, including medical status and proof of income, changes in address, phone numbers, and any changes to my name every six months, to remain eligible for any VA Ryan White Part B Program services including the Virginia Medication Assistance Program (VA MAP) services.
- It is my responsibility to notify Virginia Department of Health (VDH) of any changes in my contact information, income, insurance status, and insurance premium amount (if applicable) at any time these changes occur. If I do not provide the necessary documentation, I understand it will affect whether I can still receive services through the VDH.
- It is my responsibility to return any checks, cash, or other types of refunds that I receive from any provider if VDH has paid for those services. I understand the money belongs to VDH. This includes checks from insurance companies. I will return any refund or credit to VDH within seven days of receipt. I understand I can send the payment directly to VDH, I can drop it off to VA MAP staff at VDH, or I can give it to my Ryan White Case Manager or medical provider who will return in to VA MAP/VDH for me. I understand that keeping these refunds, credits, or checks may result in not being able to get services from VA MAP in the future.
- I understand that VDH enters my information into a confidential database that helps the program provide me the services I need.
- I understand that if I do not sign this form, VDH will not share my information. It is then my responsibility to contact each agency individually to give my information to get services. I also understand that if I change providers, such as a medical provider or case manager, it is my responsibility to inform VA MAP.

- I request third party payers to pay any authorized benefits to or for VDH on my behalf, and I will cooperate with these payers to resolve any issues for payment if needed.
- It is my right to receive quality services in a respectful and culturally appropriate manner from any agency that receives Ryan White funding from VDH, including VA MAP services provided directly by VDH. It is also my right to file a complaint against the agency or agencies where I get my services including VDH, if I feel I am not receiving services in this manner. I can file the complaint directly with the agency and understand that they are required to send a copy to VDH. Complaints against VDH may be sent directly to VDH or to its federal funder.
- It is my right to request information from my providers and VDH about my care. There may be a formal process to follow for each agency for these requests, but I understand I am entitled to ask for this information.
- I understand that I should send all readable or written documents such as grievances, checks from the insurance company, any insurance-related information related to my care, documents to support my eligibility for the Ryan White Part B program, and any changes in my information related to eligibility status to the Ryan White Part B program including VA MAP. The mailing address is Virginia Department of Health, HCS Unit, 1st Floor, James Madison Building, 109 Governor Street, Richmond, VA 23219. The fax number is 804-864-8050. Call 855-362-0658 with any questions. All checks must be sent through the mail. **Help us protect your personal health information (PHI) and personally identifiable information (PII) and DO NOT EMAIL INFORMATION.**

HIPAA PRIVACY STATEMENT

In accordance with the Health Insurance Portability and Accountability Act (HIPAA) regulation at §164.508, it is VDH's policy that using and sharing my Protected Health Information (PHI) must be made with my written consent. By signing this form, I give permission to VDH to release records necessary to support my application for payment by Medicare, Medicaid, other health care benefits, and other services under the Ryan White Part B Program. It is VDH's policy to safeguard my PHI when VDH shares it. VDH agrees to treat all PHI as confidential as required by law [HIPAA at §164.530(c)]. At my request, VDH will provide me with how my PHI was used or shared as required by law [HIPAA Privacy Rule at §164.528 and §164.514(d)(3)]. VDH will also allow me the right to look at and ask for a copy of my PHI for as long as VDH keeps the information. This permission will remain in effect as long as I, and any of my dependents remain in VA MAP, or until I withdraw it at any time, which I must send to VDH in writing as required by law [HIPAA, §164.508(b)(5)]. Send your written request to withdraw your permission to the Ryan White Part B Program Privacy Officer, HCS unit, 1st floor, 109 Governor Street, Richmond Virginia, 23219.