Client URN _____

Ryan White Service Provider Network

CONSENT AGREEMENT AND STATEMENT OF CONFIDENTIALITY FOR HEALTH CARE, CASE MANAGEMENT AND/OR SUPPORTIVE SERVICES

Client Name: _____

Date of Birth: _____

This agency, _____, is part of a network of providers which have agreed to coordinate services to provide you with health care, case management services, social and support services, and coordination of family/client care.

All clients are entitled to receive humane and dignified treatment at all times, with full respect for personal dignity and right to privacy. All records are confidential pursuant to State law. Client information is made available to funding agencies and their designees without written permission for purposes of quality assurance and reporting requirements. Information obtained by funding agencies for quality assurance and reporting requirements will utilize a coded client identifier when reported. All other client data will be maintained at the provider agency site in a secured location with access limited to provider-designated staff and quality assurance staff from funding sources.

I have read this statement, or it has been read to me, and I have been given the opportunity to have questions answered, and do understand the content. I understand that I may revoke this Consent Agreement at any time. If not revoked by me, this Consent Agreement is valid for the period of eighteen months from the date this agreement was signed.

Furthermore, this agreement will expire sixty days following the termination of services with this agency.

_____ _____

Signature of client or legal representative Date

_____

Signature of Witness

Note: This document DOES NOT authorize the release of any client information.

Revised 3/18/16;9/19