Authorization For Release Of Health Information And Confidential HIV Related Information

This form authorizes the release of confidential health information including HIV related information to **Wyoming AIDS Assistance**. Wyoming Aids Assistance provides financial assistance to Men, Women and Children living with HIV/AIDS in Wyoming. In order to provide this assistance, it is necessary that we receive certain confidential HIV related health information, and Non-HIV related health information. This information is protected as outlined in the **Privacy Policies and Practices for Protected Health Information** of Wyoming AIDS Assistance.

By checking the box below and signing this form, my Non-HIV related health information and HIV related information can be given to Wyoming Aids Assistance.

I consent to the disclosure of:

☐ Confidential Non-HIV related health and HIV related health information

Name and address of facility/person disclosing HIV-related information (**Case Manager**):

_____
_____
_____

Name and Address of Person whose information will be released (**Client**):

_____
_____
_____

Name and address of person signing this form (**Client Designee**):

_____
_____
_____

Relationship to person whose information will be released (**Parent/Guardian etc.**):_____

Time Period During Which Release of Information is Authorized: From_____ To:_____

I authorize _____ to <u>RELEASE</u> my confidential information as indicated above to Wyoming AIDS Assistance. This release is voluntary and may be revoked in writing at any time. I understand that the information will be used in accordance with the Privacy Policies and Practices of Wyoming AIDS Assistance.

_____ _____

Client or Designee Signature Date