HIV/STD/VIRAL HEPATITIS PROGRAM
RYAN WHITE PART B SERVICES
ANDREW JOHNSON TOWER, 4TH FLOOR
710 JAMES ROBERTSON PARKWAY
NASHVILLE, TENNESSEE 37243

Ryan White Part B Program
Release of Information and Client Rights and Responsibilities

The Ryan White Part B Program has developed the Participant Release of Information and Clients Rights and Responsibilities policy as a guide to help maintain quality, effective and efficient care.

AUTHORIZATION FOR RELEASE OF INFORMATION

- I certify that the information provided in this application is complete and accurate to the best of my knowledge.
- I understand that my failure to be accurate and complete may prevent or delay a determination of eligibility to receive assistance from the Ryan White Part B Program.
- I understand that, for the purposes of determining my eligibility for Ryan White Part B Program services, the Tennessee Department of Health (TDH), all Metro Health Departments and any agency contracting with them for the purpose of providing services in conjunction with the Ryan White Program may request further documentation to verify my HIV positive status, my Tennessee residency, and my financial, household size, employment or insurance information for the purpose of providing services under the program, maintaining, improving and evaluating the efficiency and effectiveness of the program, and processing claims for payment pursuant to the program.
- I authorize TDH to share the minimum necessary information with my primary care provider or their designee to confirm clinical information and acquire test results related to the service I am requesting, with the vendor pharmacy to assist with medication distribution, with other Ryan White providers in Tennessee with whom I enroll/am enrolled to maintain my enrollment in Ryan White Part B services.

PARTICIPANT RIGHTS

You have the right to **considerate and respectful care**:

- Services offered without regard or discrimination based on race, national origin, age, gender, ethnic background, disability, handicap, sexual orientation, religion, or lack of religion
- Protection from abuse or harassment from staff
- Treatment in a safe and secure environment
- Assistance in the practice of your civil rights
- Have an interpreter at no cost if you need one
- Mechanisms to facilitate access and referral to other services

You have the right to **Privacy:**

- Appropriate arrangements to ensure that there is adequate privacy during visits
- Not have any photos or videos taken of you except as needed to provide services
- Signed consent is required before any discussion or release of information can occur
- The ability to refuse information you view as not relevant to your care
- The privacy law (HIPAA) will be followed in releasing your medical information

Note: the law does require and allow Mental Health and other Human Service Professionals to report without consent
1) information or accusation of child abuse
2) threats of harm to self or others
3) information concerning crimes committed in the agency or against agency staff or property

You have the right to **involvement in decisions related to your care:**

- Refuse treatment as allowed by law and the effects of refusing treatment
- Ability to determine which services you receive
- Get information in a way that you can understand
- Be told what to expect
- Involvement of your family, significant other or any person you choose to be involved in your care
- Information concerning appointment times and the names of people caring for you, what they do and who they work for
- Ability to ask others to assist you in your care or your understanding of services
- Receive sufficient information about proposed services and other choices available
- Review and/or receive copies of your client record, according to agency policy
- Explanation of any fees that may be occurred

You have the right to **voice complaints, grievances and appeals** about the care or services provided with freedom from restraint, interference, coercion, discrimination, or reprisal. When this right needs to be exercised, staff will inform you of the established Compliant/Grievance Process and provide you with a copy of the procedures to be followed.

PARTICIPANT RESPONSIBILITIES

- I understand that it is my responsibility to certify annually by signing and submitting documentation to determine my continued eligibility for Ryan White Part B services, including proof of income, proof of residency and household size, health insurance coverage, and general updates on forms provided by TDH. I understand that changes in my situation will be evaluated to determine my continued eligibility for Ryan White Part B services.
- I understand that I must inform my medical case manager **within 30 days** of any change(s) in my financial and/or resource(s) situation.
- I acknowledge that if prescriptions are not refilled within 60 days of the refill cycle, I may be terminated from the program.
- I understand that the Tennessee Department of Health, its contractors, or subcontractors may terminate my enrollment in Ryan White Part B services if I exhibit violent or threatening behavior to a representative of TDH, its contractors or subcontractors.
- I understand that my Ryan White Part B services eligibility will terminate if:

    - I do not fully cooperate with efforts to verify information in the application for services, or
    - I do not comply with the activities needed to identify/verify potential sources of alternate coverage, or
    - I fail to seek other forms of coverage for which I may be eligible, or
    - TDH, it contractors or subcontractors become aware of material misrepresentation, withheld information, or documented fraud.
- I understand that any assistance I receive through Ryan White Part B programs is contingent upon state and federal funding. This funding is limited and may expire at any time without extended or alternative funds being available.
- I understand that completing an application for Ryan White Part B services does not ensure that I will qualify for the program.
- I understand if I am receiving financial assistance from the Insurance Assistance Program (IAP) it is my responsibility to:
    - Maintain contact with my insurance company to verify that my premium has been paid and is up to date.
    - I am responsible for providing insurance premium invoices to the IAP upon receipt from the insurance company / Tenncare.
    - If IAP has made premium payments on my insurance policy, any refunds received from my insurance company must be forwarded to IAP immediately. Failure to do so may result in suspension of IAP services.
- My signature acknowledges the fact that Ryan White service providers, contractors and employees of the TN Dept. of Health, Nashville/Davidson Public Health Department, Tenncare and Shelby County Health Dept. may release and exchange my information regarding my Ryan White eligibility so claims submitted on my behalf may be processed, in accordance with HIPAA laws and procedures. This authorization for release of information will expire (1) one year from the date noted below.

I have received a copy of the “Participant Release of Information and Clients Rights and Responsibilities policy” and understand that this information is part of the agreement to receive Ryan White Part B Services.

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Signature of Applicant **Date**

*** This Participants Release of Information and Clients Rights and Responsibilities form will expire (1) one year from the date noted above.**