DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

AIDS Drugs Assistance Program (ADAP)

Authorization for Release of Heath Information

Last Name	First Name	Middle Name	
Social Security Number	Date of Birth (MM/DD/YYYY)	Phone Number	
Street Address	City	State	Zip

The Program staff is aware of the need for confidentiality and privacy, and will discuss personal information only as strictly necessary for the administration of the Program. To provide you with an understanding of the issue of confidentiality and the conditions of the participation in the Program, the following examples are provided:

- The Program will NOT contact your employer, landlord, family, friends, neighbors, or anyone else without direct consent from you; whether directly related to your application or participation in the Programs.
- The Program can receive, verify, and/or share my demographic, medical, prescription and/or insurance information if it is needed to help me get my prescription and/or premium payments.
- The program may share my information with, but is not limited to, the following: doctor, health department staff, pharmacy staff, clinic, case management, insurance company, Medicare, Medicaid, CMS, SSA, SSDI, and other agencies where Ryan White services are provided to the client.
- The Program will discuss the application of individuals in prison with authorized employees of Parole or Corrections as needed to enroll in the Programs.

I authorize DC ADAP to contact the Alternate Contact Individuals listed below if Program staff cannot contact me for more information. I understand that I will be required to list these contacts on each submission of this form. (If you will not be providing an alternate contact, leave the boxes blank.)

Name of Alternate Contact Person 1		Phone Number	
Street Address	City	State	Zip
Name of Alternate Contact Person 2		Phone Number	
Street Address	City	State	Zip

With my signature, I authorize the DC ADAP to contact the individuals above and to share information between and among individuals or organizations with whom the program needs to discuss my application and/or participation in order to determine eligibility, pay for services or drugs covered under the programs or properly account for funds spent.

Client's Signature:_____ Date:_____