



Dear Prospective Body Positive Client,

Enclosed are the requirements Body Positive needs to have on file in order for you to access Ryan White funded services.

To continue to receive services we are required to update your income, residency and insurance every six months. If any of your information changes please notify us.

We require all documents (proof of residency, income, HIV status and insurance) **in our office or at Central Eligibility prior to scheduling** an intake appointment.

If you have any questions please feel free to contact us.

Thank You.

CHECK LIST

- ALLOWABLE PROOF OF INCOME
- ALLOWABLE PROOF OF RESIDENCY
- ALLOWABLE PROOF OF HIV STATUS
- HEALTH INSURANCE CARD

**RYAN WHITE PART A PROGRAM
RELEASE OF INFORMATION**

I authorize **Body Positive** to disclose protected health information (PHI) and other information from my records to Maricopa County Health Finance Administration, Ryan White Part A Program (MCRWPA), any other client authorized Ryan White Part A service, Walgreens/Body Positive Pharmacy Program, and my Primary Care Provider for the purpose of intake into a shared data system for demographic, eligibility, other statistical reporting, and continuity of care.

Specific description of the information to be disclosed:

The purpose of the disclosure of PHI will be for the exchange of statistical information between the party, provider, and administrative agency for the purposes described below.

Specific description of the purpose of the disclosure:

- Intake and maintenance in a shared data system for demographic, eligibility, and other statistical reporting
- Payment of vendor **Body Positive** for services rendered
- Quality assurance reviews
- Audits of Ryan White Title I services provided
- Continuity of Care

I authorize the Agency to disclose the following type of information related if required for the purposes listed above:

- AIDS/HIV and other Communicable Diseases
- Behavioral Health Care/Psychiatric Care/Mental Health Information
- Alcohol and/or Drug Abuse Treatment
- Genetic Testing Information

I understand that I may revoke this authorization at any time, unless the Agency and MCHCM have already relied on my authorization to disclose information. To revoke my authorization, I must submit a written request to: Body Positive, 1144 E. McDowell rd # 200, Phoenix, Az. 85006.

Unless I revoke this authorization earlier, it will expire in five years from date signed.

I understand that MCHCM will maintain the confidentiality of any disclosed information and will use and disclose this information only for the purposes listed above. I understand the matters discussed on this form. I release MCHCM and Agency, its employees, officers and directors, medical staff members, and agents from any legal responsibility of liability for the disclosure of the above information to the extent indicated and authorized herein.

Printed Name

(Date of Birth)

Signature
(of Ryan White Part A client Authorizing disclosure)

(Date)

Signature of Legal Representative

Relationship to Patient or Description of Authority



Consent for Purposes of Treatment, Payment and Operations

I consent to the use of disclosure of my Protected Health Information by Body Positive for the purpose of providing treatment to me, obtaining payment for my care or to conduct operations of Body Positive. I understand that any service Body Positive provides may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the agency. Body Positive is not required to agree to the restrictions that I may request. However, if Body Positive agrees to a restriction that I request, the restriction is binding on Body Positive and all of its providers.

I have the right to revoke this consent, in writing, at any time, except to the extent that Body Positive has taken action in reliance on this consent.

My "Protected Health Information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Body Positive's Notice of Privacy Practices prior to signing this document. Body Positive's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment for my services or in the performance of operations of Body Positive. The Notice of Privacy Practices for Body Positive is also posted in this office. This Notice of Privacy Practices also describes my rights and Body Positive's duties with respect to my protected health information.

Body Positive reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Print Name of Patient or Personal Representative

Signature of Patient or Personal Representative

Date

Description of Personal representative



An HIV and AIDS Research and Resource Center

BODY POSITIVE VITAMIN & HERB SHOP

Release of Liability

I am a client of Body Positive and have voluntarily chosen to purchase products from the Vitamin & Herb Shop at my own risk and based upon my own independent judgment. I understand that the Vitamin and Herb Shop does NOT provide medical diagnosis or advice or prescribe treatment for specific individuals or medical conditions but rather collects and distributes information on complimentary therapies, products and protocols that may be appropriate for medical problems related to the Human Immunodeficiency Virus (HIV) and/or other medical problems.

I realize that the information disseminated by the Vitamin & Herb Shop does not constitute a medical claim or endorsement of the effectiveness of a particular product, therapy or protocol for my particular medical condition. I understand that I am free to purchase or otherwise obtain only those products that I wish to use and acknowledge that I have not been pressured or coerced into purchasing or otherwise obtaining a particular product or combination of products by anyone affiliated with the Vitamin & Herb Shop.

I release the Vitamin & Herb Shop and anyone affiliated with the Vitamin & Herb Shop, including but not limited to its' volunteers, employees, officers, advisors, and Board of Directors from any liability (including but not limited to liability resulting from Vitamin & Herb Shop negligence) in connection with the sale or use of any product which I purchase or otherwise obtain from the Vitamin & Herb Shop or which is described in any of the Vitamin & Herb Shop's information materials. I understand that I am giving up my right to file a lawsuit for any damages resulting from my use of any product which I buy or otherwise obtain from the Vitamin & Herb Shop or which is described in any of the Vitamin & Herb Shop's informative material.

I have read this Limitation of Liability notice and understand that it is my responsibly and obligation to review any information, product, therapy and protocol with a qualified health care professional.

I understand that I am assuming the risk of any adverse effects and consequences resulting from my use of any product purchased or otherwise obtained through the Vitamin & Herb Shop or described in any information provided by the Vitamin & Herb Shop.

Client Name (Please Print): _____ Date: _____

Client Signature: _____