Consent for the Collection and sharing of Patient Information under the Ryan White Program

This agency, _____, is required to collect certain personal information that is entered and saved in a database called the Louisiana CAREWare Access Network (LaCAN). Agencies across Louisiana collect this information to improve services and coordinate appropriate referrals for you.

You do not have to share your information to receive services at these providers; but there are several benefits to sharing your information. By agreeing to share your information with other HIV service providers, you will save valuable time by not having to provide the same information again.

Sharing your information is voluntary, and you have the right to opt out of electronic sharing. You may withdraw this release at any time by notifying your social worker/case manager in writing of your request. Please note, you may revoke this authorization at any time, but the program may already have released information.

The database allows for certain medical and support service information to be shared among providers involved with your care. This includes lab records maintained by the Louisiana Department of Health Office of Public Health STD/HIV Program and the Louisiana Health Access Program (LAHAP). This protected health information may include, but is not limited to, demographic information, information regarding your HIV status, medical visits, lab results, medications prescribed, emergency financial assistance, nutritional supplements, case management, and transportation. Counseling information and notes including psychiatric, mental health, substance abuse and legal progress notes will not be shared with anyone but those personnel who are providing those services.

Your information is safeguarded and kept confidential. LaCAN records are maintained in an encrypted statewide database, on a secure server. Only providers where you receive services and who have permission to access client data can see your information.

LaCAN reports may be used for advocacy and program evaluation, both statewide and federally, and any client information used will be done so without revealing names or other information that would identify you. The information is also used to ensure compliance with contracts and clinical standards.

By signing this consent, I release all Ryan White Grantees and Contractors, their employees, officers, directors, medical staff, and agents from any legal responsibility or liability for the disclosure of information to the extent indicated and authorized in this consent.

I agree to have my information: ☐ **SHARED** ☐ **NOT SHARED**

This consent shall expire three years from the date of this document.

_____	_____	_____
Client Name and DOB	**Client Signature** **Parent/Guardian Signature (if a minor)**	**Date**
_____	_____	_____
Agency Representative Name	**Representative Signature**	**Date**

Authorized Release Period

Consent Start Date: _____

Consent End Date (3 years after start date): _____