



*PERMISSION TO SHARE CONFIDENTIAL AND OTHER INFORMATION*

Date: \_\_\_\_\_

I, \_\_\_\_\_ authorize the personnel of Grace Specialty Care to share with the City of Detroit, Department of Health and Wellness Promotion and the State of Michigan my identity information related to HIV/AIDS evaluation and treatment, and information related to Ryan White Care Act Services. Grace Specialty Care personnel may contact the above individuals/agencies for purposes of securing and/or sharing information and records.

I understand that Grace Specialty Care is a recipient of Ryan White Care Act Funds, which are used to support my care. Grace Specialty Care is required to report statistical and demographic data to the City of Detroit Department of Health and Wellness Promotion and the State of Michigan for Part A, Part B, Part C, and Part D funds. Client level data related to my specific care plan may also be reported through any client level service utilization database required by the grantee.

Authorized representatives of the grantee may also review client paper and/or electronic records, files and documentation as part of on-going site visits, quality assurance process and/or objective peer review in accordance with the Governmental Performance and Results Act. The GPRA information is used to document progress toward specific measurable objectives, demonstrate program quality and effectiveness, and to support Care Act appropriation and reauthorization. HIV status must be documented for Care Act federal legislative purposes.

The purpose of this release is limited to permitting personnel of Grace Specialty Care to attempt to secure services, which they and I, or my authorized representative(s), have agreed will be of benefit to me. Unless and until I have completed and signed additional release forms for specific purposes, Grace Specialty Care personnel may not share any information which might identify me with any other organization.

I understand that I may revoke this authorization at any time and this revocation will be effective except for information already disclosed.

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I CONSENT to Dr. Hafeez office (WSU Grace Specialty Care) sharing my information with the City of Detroit Department of Health and Wellness and the State of Michigan.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_