AIDS Drug Assistance Program
Health Insurance Assistance – Family Plan

CONSENT FORM

Consent to Participate and Consent to Release Personal and Medical Information

This consent form applies to you only if you:

- are specifically enrolled in, applying for, or receiving the benefits of, the health insurance assistance program within the AIDS Drug Assistance Program (ADAP), which provides health insurance premium payment and medical out-of-pocket cost payment assistance to eligible ADAP clients, and
- are enrolled in a family health insurance plan (regardless if you are the main policy holder) that includes at least one member who is separately enrolled in ADAP.

In order to administer the health insurance assistance program within ADAP, including the furnishing of health insurance premium and medical out-of-pocket cost payments on your behalf, and on behalf of any member included on your family health insurance plan who is separately eligible to receive ADAP's health insurance premium and medical out-of-pocket cost payment assistance, the California Department of Public Health (CDPH) or its agents may need to disclose, confirm and/or exchange information regarding your enrollment in ADAP (including but not limited to your ADAP client ID number, name, date of birth, health coverage information such as your health plan name and premium amount) to that member and/or that member's ADAP enrollment worker.

By signing this form, I consent to allow CDPH and its agents to disclose, confirm, and/or exchange information, as necessary, regarding my enrollment in ADAP to any member included on my family health insurance plan who is also separately eligible for and/or enrolled in ADAP and to that member's enrollment worker, for the purpose of determining my eligibility for the health insurance assistance program and for the purpose of administering the program. By signing this form, I understand that by confirming my enrollment in ADAP to a member of my family health insurance plan who is separately enrolled in ADAP or to that member's ADAP enrollment worker, I am indirectly disclosing my HIV status.

I consent to disclose information regarding my enrollment in, or eligibility for, ADAP to the applicable entities and for the purposes described above, as necessary for the health insurance assistance program for which I am enrolled in, applying for, or receiving the benefits of.

This consent shall remain in effect for two (2) years from the date of my signatures below. A photocopy of this consent shall be considered as valid as the original.

Applicant's Name (print):_____

Applicant's Signature:_____

Date:_____