AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

YOU DO NOT HAVE TO SIGN THIS FORM. YOUR DECISION NOT TO SIGN THIS FORM WILL NOT AFFECT YOUR TREATMENT, HEALTHCARE, ENROLLMENT IN HEALTH PLANS, OR ELIGIBILITY FOR BENEFITS FOR WHICH YOU ARE OTHERWISE ENTITLED.

_____ _____

Printed Name Telephone Number

_____

Email Address

AUTHORIZES THE RELEASE OF PROTECTED HEALTH INFORMATION:

By signing this Authorization Form, I understand that I am giving my authorization for ETSU Health Infectious Disease to disclose my protected health information (PHI), as described in detail below, to:

The Executive Director, or their team, of the East Tennessee State University Center for Inflammation, Infectious Disease

I understand that if the person(s) and/or organization(s) listed above are not healthcare providers, health plans or healthcare clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

INFORMATION TO BE RELEASED:

I authorize my name, telephone number and email address as printed on this form be released as described in this Authorization Form.

_____
Patient Initials

Additionally, I authorize my diagnosis with HIV/AIDS to be released as described in this form. While no medical records will be released from ETSU Health Infectious Diseases under this Authorization, because participation on the Center's Patient Advisory Board is for patients with HIV/AIDS, your diagnosis will be indirectly shared with the Executive Director and their team.

PURPOSE: The purpose of this authorization is to allow your healthcare provider to give your contact information to The Executive Director, or their team, of the East Tennessee State University Center for Inflammation, Infectious Disease and Immunity so that you may be contacted about your interest in participating on the Center's Patient Advisory Board.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

You do not have to sign this form. However, your decision not to sign this form will result in you not being contacted to participate in the Patient Advisory Board listed above. If you sign this form, you will be provided with a signed copy of the form. If you sign this form and later change your mind you may revoke your authorization by contacting Maria Ramirez at 423-930-8337. To revoke this authorization, you must do so in writing by sending a written letter to: Maria Ramirez, c/o ETSU COE 635 N. State of Franklin Rd, Johnson City, TN 37604 Your revocation will not be effective as to uses and/or disclosures of health information that the person(s) and/or organization(s) listed above already made in reference to this authorization prior to your written cancellation.

EXPIRATION DATE: This Authorization expires at the conclusion of your participation on the Center's Patient Advisory Board.

By signing below, you confirm that you have had an opportunity to review the above and understand the content of this Authorization Form. By signing below, you are confirming that this form accurately reflects your wishes.

Patient Signature: _____ Date: _____