Patient Name:_____

MRN:_____ CSN:_____

D.O.B:_____ Admit Date:_____

University Health

RYAN WHITE & OPERATION BRAVE PROGRAMS

e2San Antonio Consent Form

I, _____(Client/Legal Guardian) acknowledge that University Health (hereinafter referred to as AGENCY) is part of a health network of care that provides one or more services for people living with HIV under the Ryan White Part A, Ryan White Minority AIDS Initiative (MAI), Ending the HIV Epidemic (EHE) Operation BRAVE, Ryan White Part B Service Delivery, State Services, State Funds, Ryan White Part D and/or Housing Opportunities for Persons With AIDS (HOPWA) Programs (hereinafter referred to collectively as Network) within the San Antonio Service Delivery Area. I acknowledge that payment for services rendered by Network Service Providers of the University Health Ryan White and Operation BRAVE Programs are contingent upon my Authorization below.

I acknowledge that the University Health Ryan White and Operation BRAVE Program Administration and its Network Service Providers are mandated to collect certain personal information that is entered and saved in a database system called Electronic Comprehensive Outcomes Measurement Program for Accountability & Success (e2SanAntonio or eCOMPAS). The e2SanAntonio records are maintained in an encrypted database, in a secure server by RDE and the University Health Ryan White and Operation BRAVE Program Administration.

I consent to and authorize AGENCY to input my personal information into e2SanAntonio, including but not limited to: demographic data, Social Security Number, contact information, Financial/Employment, Insurance, assigned client identification code, HIV/AIDS status, clinical-medical data, case notes, support service utilization, client assessments, and socioeconomic data.

I acknowledge that all Network Service Providers that I receive Ryan White and/or Operation BRAVE services from will have access to all of my information in the e2SanAntonio system. I acknowledge that this information will be shared with Network Service Providers to which I apply for Ryan White and/or Operation BRAVE services that requests the information for the purpose of informing and coordinating treatment and benefits I receive under the Ryan White and/or Operation BRAVE Program. I acknowledge that Network Service Providers will need my exact names and date of birth to search for my information in the e2SanAntonio system and that the search feature is intended to eliminate barriers to accessing services such as the duplication of applications. I acknowledge that if I fail to show for scheduled medical and other support appointments, I may be contacted by an authorized representative of the AGENCY in order to re-engage and link me back to care. I consent to and authorize Network Service Providers to whom I do not receive Ryan White and/or Operation BRAVE services from to search for my information in the e2SanAntonio system for the purposes of locating, initiating contact, and/or offering assistance with linkage/re-engagement to HIV care and treatment.

I give consent to and authorize University Health Ryan White and Operation BRAVE Program Administration to allow the disclosure and sharing of the information entered into the

encrypted e2SanAntonio database program to any Network Service Provider, the Health Resources and Services Administration (HRSA), the Texas Department of State Health Services (DSHS), their program and administrative staff or consultants.

I consent to give University Health Ryan White and Operation BRAVE Program Administration, Health Resources and Services Administration (HRSA), and the Texas Department of State Health Services (DSHS) access to any and all records stored in the system and any other records held by any Network Service Providers for the purpose of monitoring, reporting, operating, payment, and administration.

This Authorization will remain valid until revoked. If I revoke this Authorization form, I understand that I must do so in writing and that I must present my written revocation to this AGENCY and University Health Ryan White and Operation BRAVE Program Administration. I understand that the revocation will not apply to any personal or health information that has been released prior to the revocation. A written revocation will be effective five (5) days after is it received by AGENCY and University Health Ryan White and Operation BRAVE Program Administration. I understand that services rendered after the date of revocation will not be paid for by the Ryan White and/or Operation BRAVE Programs.

By signing below, I accept the terms stipulated above. I stipulate that reproduction of this signed Authorization are authentic as original.

If the signer is a legal guardian, legal documentation of the representative's identity and authority to act on the individual's behalf must be attached. For a minor, the parent must attach a copy of the birth certificate to this form.

_____ _____

Client Name (Please Print) Client Signature

_____

Date

_____ _____

Legal Guardian (Please Print) Legal Guardian Signature

_____ _____

Legal Guardian's Relation to Client Date

_____ _____

Witness Name (Please Print) Witness Signature

_____

Date