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| AUTHORIZATION TO RECEIVE AND DISCLOSE INFORMATION AIDS/HIV DRUG ASSISTANCE AND INSURANCE ASSISTANCE PROGRAMS |
| I authorize the Wisconsin Department of Health Services (DHS) to receive and disclose medical information related to my HIV status and to receive and disclose information about my private or public health insurance coverage to DHS staff, my designated pharmacy, my physician, my case manager, my private insurance company and/or my employer as needed to determine and maintain my eligibility for benefits under the Wisconsin AIDS/HIV Drug Assistance Program (ADAP) and/or the Insurance Assistance Program (IAP), and to administer these programs. I understand that this information will be disclosed confidentially to a third party vendor for pharmacy claims processing and/or insurance premium payment processing and for administrative purposes. Except for information already received or disclosed, this authorization may be revoked at any time by notifying ADAP and IAP in writing at the address below; however, revocation of this authorization will result in disenrollment from the program(s).Unless revoked, this authorization will remain in effect for one year from the date it is signed.I hereby certify that all the information I have provided in this application/recertification is true and complete. I understand that I am subject to termination of my enrollment and possible prosecution under state and federal laws if this information is false. |
|  |  |  |
| **SIGNATURE** - Applicant or Guardian |  | Date Signed  |
| Print Name of Applicant or Guardian |

For electronic submission only.

**ADAP and IAP Mailing Address:**

ADAP and IAP

Division of Public Health

PO Box 2659

Madison, WI 53701-2659