

RYAN WHITE PROGRAM CARE/HIPP PHYSICIAN'S STATEMENT

SECTION 1 - APPLICANT INFORMATION

NAME OF APPLICANT- Last _____

First _____

SECTION 2 - APPLICANT RELEASE OF MEDICAL INFORMATION

IMPORTANT: Please note that the information on this form is in accordance with the Ryan White HIV/AIDS Treatment and Modernization Act of 2006 and is required by the California Department of Public Health, CARE/HIPP Unit. The information will be used to determine your eligibility for the CARE/HIPP Program. Furnishing the information on this form is mandatory. Failure to provide the mandatory information may result in benefit enrollment elections not being processed or being processed incorrectly. You have the right to review the information maintained by the California Department of Public Health unless access is exempt by law. To access the information, contact the California Department of Public Health, CARE/HIPP Unit, MS 7704, P.O. Box 997426, Sacramento, CA 95899-7426, (916) 449-5900.

"I _____, hereby authorize the below-named physician or health care provider to release my medical information requested on this form to the California Department of Public Health (CDPH). I understand that CDPH will use the information to determine my eligibility for the CARE/HIPP Program."

X _____
Applicant's Signature

Date

SECTION 3 - PHYSICIAN/HEALTH CARE PROVIDER STATEMENT

Are you treating the applicant/patient listed above? Yes [] No []

Is the applicant/patient disabled and unable to work full time? Yes [] No [] If Yes, check one of the following:

- Disabled due to HIV
- Disabled due to AIDS
- Disabled due to other condition(s): _____

Additional information? _____

SECTION 4 - PHYSICIAN/HEALTH CARE PROVIDER INFORMATION

PHYSICIAN/HEALTH CARE PROVIDER NAME (Please Print) _____

TELEPHONE NUMBER
() _____

X _____
Physician's/Health Care Provider's Signature

Date