Pre-Exposure Prophylaxis Assistance Program (PrEP-AP) Client Consent to Collection of and Authorization to Disclose Personal and Medical Information

The Pre-Exposure Prophylaxis (PrEP) Assistance Program (PrEP-AP) is a subsidy program administered by the California Department of Public Health (CDPH), Office of AIDS, to assist with certain costs of medication for the prevention of HIV infection and other related medical services for eligible individuals. Individuals applying for PrEP-AP services must meet eligibility standards. Services are only available to persons who reside in California, are HIV-negative, are uninsured or underinsured, are not fully covered by Medi-Cal, and have a modified adjusted gross income up to 600 percent of the federal poverty level based on family size and household income. CDPH contracts with enrollment agencies, clinical providers, and other entities (collectively, "agents") to help administer PrEP-AP.

By signing this form, you are authorizing CDPH and its agents to obtain information about you from other state and federal agencies or your health care provider(s) in order to verify your eligibility for PrEP-AP. You are also authorizing the enrollment agencies to collect information from you in order to enroll you in PrEP-AP.

The information you are authorizing CDPH and its agents to obtain includes your name, date of birth, Social Security Number, income, demographic data, HIV test results, diagnosis and other medical information, and health benefits information.

Only authorized personnel at CDPH's agents will have access to your information, and only on a need-to-know basis, as required under California law and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Confidentiality agreements are in place which keep client information confidential except with specific client authorization or as otherwise permitted by law. Information disclosed may be subject to re-disclosure and is no longer protected if it is disclosed to anyone other than a covered entity.

By signing this form, you are authorizing CDPH and its agents involved in administration of PrEP-AP to collect and use your information and you are consenting to their disclosure of information about you for the following purposes:

- To and from each other to verify program eligibility and for coordination of care and benefits, program monitoring and evaluation, and other purposes directly connected with administration of PrEP-AP.
- To and from each other to comply with state and federal reporting requirements.
- To and from the Department of Health Care Services, the Franchise Tax Board, Covered California, the Centers for Medicare and Medicaid Services, and other federal and state agencies as necessary to verify program eligibility and other purposes directly connected with administration of PrEP-AP.
- To and from your health care provider(s) to coordinate medication billing coverage and other purposes directly connected with administration of PrEP-AP.
- To and from your local health department for program monitoring and evaluation and to facilitate linkage to care.
- To and from the California State Auditor, the California Center for Data Insights and Innovations, the California Office of Information Security, or other state and federal agencies as required by law.

Under state law, PrEP-AP is a payer of last resort. If it is determined that services or items obtained from PrEP-AP should have been paid by other federal, state, or private entities, PrEP-AP or its agents may disclose your information to those entities for the purpose of obtaining reimbursement. This process may trigger an explanation of benefits that may be sent to the primary policyholder, who may not be the PrEP-AP client.

You agree that your consent and authorization in this form shall remain in effect for one year from the date of your signature below, and a digital or photocopy of this form shall be considered as valid as the original.

You have the right to modify or revoke this consent and authorization in writing by contacting cdphmedassistfax@cdph.ca.gov. You also have the right to receive a copy of this form.

I hereby consent to and authorize the collection, use and disclosure of my personal information as set forth above.

Client/Representative Name: _____
(Print)

Client/Representative Signature: _____ Date: _____

*If you are signing as a legal representative on behalf of the client, please provide documentation evidencing your appointment as the client's legal representation.