# INSURANCE ASSISTANCE CONSENT FORM

## Consent to Participate and Consent to Release Personal and Medical Information

The California Department of Public Health (CDPH), Insurance Assistance Programs provide health insurance premium payment assistance to low-income individuals living with human immunodeficiency virus (HIV). Individuals applying for these services must meet eligibility standards. Services are only available to individuals living with HIV/AIDS, who reside in California, are at least 18 years old, and have a modified adjusted gross income that does not exceed 500 percent of the federal poverty level per year based on family size and household income.

To verify eligibility for this program, CDPH, or its agents may be required to obtain personal information from other agencies or health care providers. If you agree to take part in a CDPH insurance assistance program, the enrolling agency will collect personal information including your name, date of birth, address, Social Security Number, medical history, and financial eligibility for the program. The information will be considered confidential, but may be released to CDPH, enrollment workers, Consolidated Omnibus Budget Reconciliation Act (COBRA) administrators, health insurance companies, employers and employer administered health insurance plans, health care professionals who provide services to you, CDPH contractors associated with the administration of the program, and other governmental or public agencies as necessary to determine your eligibility and for the purpose of administering the program.

Information that you provide for your application may be made available to your local health department for statistical purposes. This information includes, but is not limited to, gender, ethnicity, zip code, diagnosis status, and date of birth. This information may also be used for professional writings under strict assurances that all identifying information including name and Social Security Number is deleted. Any professional or research reports that may be published will not use your name nor any personal identifying information.

I, _____, consent to release of personal and medical information as described above to CDPH, enrollment workers, COBRA administrators, health insurance companies, employers and employer administered health insurance plans, health care professionals who provide services to me, CDPH contractors associated with the administration of the program and other governmental or public agencies as necessary to determine my eligibility for services and to administer the program. This consent shall remain in effect for two years from the date of my signature below unless revoked by me in writing. A photocopy of this consent shall be considered as valid as the original.

_____ _____

Applicant's Signature Date

_____ _____

Enrollment Worker's Signature Date

| Enrollment Site Name | Enrollment Worker Name | | |
|---|---|---|---|
| Enrollment Site Address (Number, Street, Suite #) | City | State | Zip Code |
| Enrollment Site Telephone Number | Enrollment Worker Email Address | | |