INSTRUCTIONS: Coordination of Confirmatory Testing Authorization

Purpose of Authorization:
The purpose of this authorization is to allow the client and the Walgreens site that provides HIV testing to identify and select available community resources. The goals are to help coordinate referral services, assist with closing the referral loop, and allow easier linkages to care.

Please remember, if the authorization is not complete and accurate, it may delay obtaining additional services for your client.

1. The Walgreens pharmacist or the client need to print the client's full name, address, and date of birth on the top portion of the authorization.
2. The Walgreens pharmacist will check off the appropriate confidential information to be exchanged.
3. The Walgreens pharmacist will indicate any other information not listed by manually writing in the information.
4. The Walgreens pharmacist will indicate if the client was already aware of their positive HIV status because of a previous HIV test and may or may not currently be in HIV care.
5. The Walgreens pharmacist will mark which service requested. The connecting/reconnecting to care selection is for clients who already knew they were living with HIV because of a previous test, and may want to be connected/ reconnected into HIV care.
6. The client will need to advise Walgreens representatives of the best contact method(s), phone, email, or letter. If best by phone the best time to call, and if it is appropriate to leave a voicemail message on the home, cell, or work phone.
7. The Walgreens pharmacist will write in the **authorization effective date** and advise the client that the authorization date is valid for **24 months** from the signature date. If revoked, the **Client must sign and date**. The client is responsible for contacting the agencies to withdraw from their services. A copy of the authorization will be provided to the client.
8. The client will sign and date the authorization acknowledging the purpose of the authorization.
9. The Walgreens pharmacist who explained and completed the authorization with the client will write their name, store ID number, and store phone number on the bottom of the form.
10. The Walgreens pharmacist will fill in the name of the Linkage to Care specialist to whom the form will be faxed, their agency, and their phone number.

The Walgreens representative will complete the authorization and fax it to the appropriate agency(ies) named on the authorization for referral. **Please be sure to use a fax cover sheet.**

1. The pharmacist will fax the Coordination of Confirmatory Testing Authorization to the appropriate linkage to care specialist.
2. The pharmacist will write in their telephone number.

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-02271 (01/2018)

COORDINATION OF CONFIRMATORY TESTING AUTHORIZATION

Name - Client (First, Initial, Last Name)	Date of Birth (mm/dd/yyyy)

The following confidential information can be shared:

☐ Contact information (telephone number, address) ☐ Demographics (age, race, sex, etc.) ☐ Test results

☐ Other information: ____________________

I consent that my confidential information above can be shared by Walgreens with the Linkage to Care agency(ies) listed below for the following referral arrangements:

☐ Confirmatory HIV testing ☐ Connecting/Reconnecting to HIV care

I have previously received a confirmed, positive HIV test before today's test. ☐ Yes ☐ No

I would prefer to be contacted by the following method: (please check all that apply)

☐ In person only, at this location: ____________________

☐ Home Phone ____________ May we leave a message? ☐ Yes ☐ No

☐ Cell Phone ____________ May we leave a voice/text message? ☐ Yes ☐ No

☐ Work Phone ____________ May we leave a message? ☐ Yes ☐ No

☐ Email ☐ Letter

What is the best time to reach you? ☐ Morning _________ ☐ Afternoon _________ ☐ Evening _________

By signing below,

I understand that each agency must have specific information to provide services and benefits. By signing this form, I allow agencies to share certain information about me, for the purposes of coordinating my follow up testing pertaining to my HIV test results. I further understand that only information relevant to the coordination of my follow up testing will be shared among pertinent staff.

I understand that this authorization for the **coordination of my care services** is valid for **24 months** from the authorization date.

In addition, I understand that in order to assist in the referral process, a health system navigator (HSN), or patient navigator (PN), or other type of linkage to care staff or personnel can attempt to contact me by the above-approved methods, in the event that I miss a scheduled appointment related to my confirmatory HIV testing.

I can withdraw this authorization in writing at any time by informing all referred agencies. The listed agencies must stop sharing informationafter I inform them that my authorization has been withdrawn. If I do not sign this form, information will not be shared and I will have to contact each agency individually to give information about me that is needed. However, I understand that treatment and services cannot be conditioned upon whether I sign this authorization. I also understand if information is redisclosed, the recipient of the redisclosed information may be controlled by different laws.

I agree that information may be shared as outlined in this authorization after the authorization is signed.

SIGNATURE – Client (or Authorized Person)	Date Signed

Name of Person explaining this authorization	Store ID Number	Store Phone Number

Effective Authorization Date	**Acknowledge Authorization is Revoked – Client Sign and Date**

Name of Linkage to Care Specialist(s) Referred to:	Agency(ies)	Phone Number

Please fax this sheet to Linkage to Care Specialist AND State HIV Program, 608-267-3583