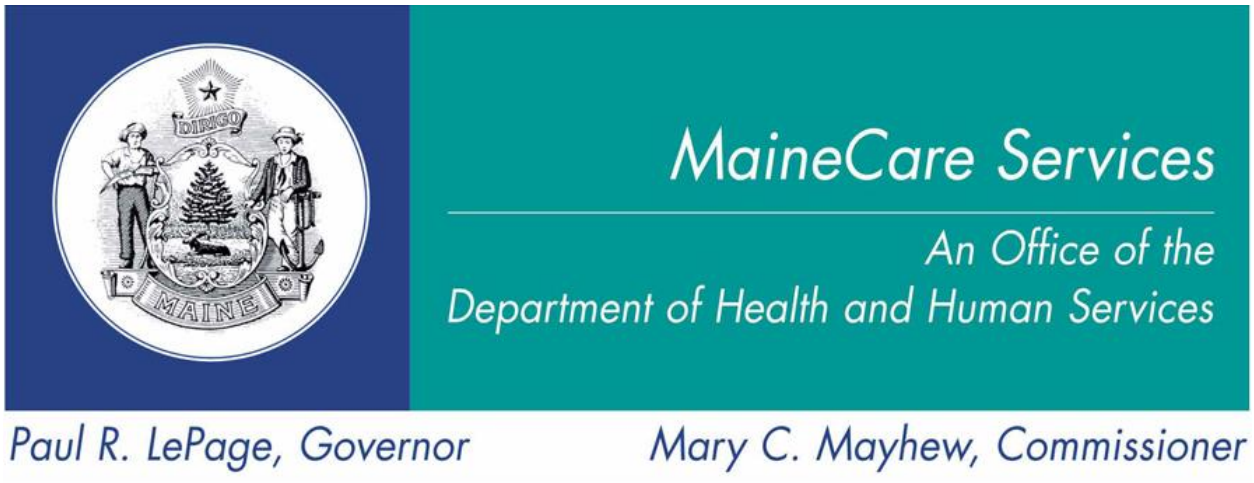


Maine Seal

Quarterly Report

HIV/AIDS 1115 Demonstration Project

SFY 2015 Quarter 3

DY 13 Quarter 1

(1/1/15 - 3/31/15)

MaineCare Services
An Office of the
Department of Health and Human Services
Paul R. LePage, Governor Mary C. Mayhew, Commissioner
Maine Seal

Department of Health and Human Services
MaineCare Services
Nurse Coordinator
11 State House Station
Augusta, Maine 04333-0011
Tel.: (207) 287-4758; Fax: (207) 287-1864
Toll Free (866) 796-2463; TTY Users: Dial 711 (Maine Relay)

May 29, 2015

Ed Francell
Division of State Demonstrations and Waivers
Center for Medicaid and CHIP Services, CMS
Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Mr. Francell,

Please find enclosed, the quarterly report for the Maine HIV/AIDS Section 1115 Demonstration Waiver for the quarter ending 3/31/15. Please contact Emily Bean at (207)-624-4005 if further information is needed.

Sincerely,

[redacted]

Stefanie Nadeau, Director
Office of MaineCare Services
11 State House Station, Augusta, ME 04333-0011
Phone: 207-287-2093

cc: Julie Sharp, CMS/CMCS
Aimee Campbell-O'Connor, CMS/CMCHO
Kevin Flanigan, MD
Sheena Bunnell, PhD

Maine HIV/AIDS Demonstration

Section 1115 Quarterly Report

Demonstration Year: 13 (01/01/2015 - 12/31/2015)

Demonstration Quarter: 1 (1/01/2015 - 3/31/2015)

Maine Fiscal Quarter: 3/2015 (01/01/2015 - 03/31/2015)

Introduction

The MaineCare HIV/AIDS 1115 Demonstration project has completed the first quarter of its thirteenth year. This demonstration was implemented on July 1, 2002 and has been approved through December 31, 2015. The demonstration's goal is to provide critical services to people living with HIV/AIDS in order to delay, prevent, or reverse the progress of their disease.

Enrollment Information

During the first quarter of the thirteenth year, there were 800 MaineCare and demonstration members enrolled in the demonstration project.

Enrollment Counts

There were 502 demonstration enrollees included in the quarter. These members qualified by having a diagnosis of HIV/AIDS and income at, or below, 250% of the Federal Poverty Level (FPL). There were 334 Medicaid members included in the quarter. Medicaid members are identified as either the original cohort of members who are receiving MaineCare, or MaineCare members where 25% or more of their Medicaid claims are HIV-related.

Demonstration Populations (as hard coded in the CMS-64)	Count of members enrolled at Start of Quarter	Count of members enrolled During the Quarter	Number of Persons Disenrolled during Quarter for non-payment of premiums*	Number of Persons Disenrolled during the Quarter**	Number of Members who Changed FPL	Members who Switched Rate Codes	Count of members enrolled at End of Quarter
Enrollees at or below 100% FPL - Demonstration Enrollees	175	201	N/A	(17)	(10)	(4)	170
Enrollees above 100% FPL - Demonstration Enrollees	279	302	0	(4)	(9)	(0)	289
Members HIV Positive and MaineCare Eligible	312	334	N/A	(19)	N/A	(3)	312
Totals	766	837	0	(40)	(19)	(7)	771

Note: The numbers in the above chart come from different data sources; therefore, they may not reflect accurate enrollment counts as they are based on FPL.

*Enrollees who fail to pay premiums within the 60-day grace period could lose coverage until premiums are paid. If the coverage is reinstated with no lapse, they will not be considered "disenrolled." (Example: a member has unpaid premiums and their coverage is closed on July 31st. On August 8th, the balance is received and the member is reopened with an August 1st start date. Since the coverage was retroactively opened, they would not be counted as disenrolled).

**Reasons an individual disenrolls could include: moving out of state, going over income, becoming deceased.

Outreach/Innovative Activities

Outreach is ongoing. Methods used for outreach during this period included:

- Attending the monthly Ryan White meeting. People present were case managers, members, providers, and representatives from other various agencies.

- Attending the monthly HIV Advisory Committee (HIVAC) meetings. Present were representatives from case management agencies, the AIDS Drug Assistance Program (ADAP), Maine Center for Disease Control and Prevention (CDC), Office of MaineCare Services (OMS), legislators, people living with HIV/AIDS, and appointed committee members.

- Attending weekly Decision Support System (DSS) User Group meetings to discuss the DSS and system issues, workarounds, and resolutions.

- The Nurse Coordinator making calls to members who had not been contacted in six (6) months or more (see enclosure 5).

- Referring more members to Consumers for Affordable Health Care to help with their unmet healthcare needs/coverage.

- Sending FDA medication alerts to primary care providers regarding Stribild, Evotaz, Prezcobix, and Kaletra. Alerts are sent via mail or email depending on provider preference (see Attachment A: Outreach). Alerts were typically sent to approximately 275 providers.

- Sending the spring poster and brochure mailing to high schools and universities. The mailing was sent to 156 locations.

- Continuing with the new Emergency Department (ED) reporting process that incorporates a daily census from each hospital, in addition to the regular monthly report (which has a two month lag time).

- Sending the program's new authorization form to new members and members whose current form was outdated (see Attachment A: Outreach).

- Nurse Coordinator and Program Manager attending a training on writing skills. This training covered: knowing your audience, organizing materials, recording observations, plain language, grammar and punctuation, and email etiquette.

- Sending a lab request letter to twenty-seven (27) providers requesting members' most recent CD4 and viral load results.

- Sending the 2014 provider survey to 317 providers (both primary care physicians and infectious disease specialists).

- Sending the 2014 member survey to 762 members.

- The Nurse Coordinator attending a conference titled "Reasoning with Unreasonable People: Focus on Disorders of Emotional Regulation." The class outlined strategies to communicate effectively with mood disorders, anxiety, OCD, anger, and personality. The course also went over ways of reasoning or having a difficult conversation with people who are experiencing pain, illness, or are vulnerable. Several calming strategies were taught in the class in order to communicate with individuals experiencing strong emotions.

Operational/Policy Development/Issues

Co-payments and premiums (for waiver enrollees)

Waiver enrollees pay all of the regular Medicaid co-payments except for:

Physician visit: co-pay is $10.00

Prescription drugs: co-pay is $10.00/30-day supply for generic medications
co-pay is $20.00/90-day supply for brand name medications
(by mail order only)

- The Maine ADAP pays deductibles, premiums, and co-pays (for medications on the ADAP's formulary). This coverage wraps around MaineCare, Medicare Part D, and private insurance. The ADAP covers medications to treat: HIV, mental illness, high blood pressure, high cholesterol, hepatitis, diabetes, thyroid disease, heartburn, nausea, diarrhea, antibiotics, contraceptives, estrogen, and vaccines. The full ADAP formulary can be found at: http://www.maine.gov/dhhs/mecdc/infectious-disease/hiv-std/provider/documents/adap-quarterly-formulary.pdf.
- The ADAP assists with co-pays in the following way:
    - The ADAP pays 100% of the co-pay (for formulary medications) for members with MaineCare (up to $10 per 30-day supply).
    - The ADAP pays 100% of the co-pay (for formulary medications) for members with MaineCare and Medicare Part D (up to $5 per 30-day supply as this is the maximum co-pay amount).
- Enrollees with an individual income of 150% of the FPL or higher are required to pay a monthly premium to receive services under the waiver. If a member submits their premium bill to the ADAP, the program will assist them with these payments. The premium amounts are as follows:

INCOME LEVEL	MONTHLY PREMIUM
Equal to, or less than, 150% of Federal Poverty Level	0
150.1% - 200% of Federal Poverty Level	$32.59
200.01% - 250% of Federal Poverty Level	$65.17

*Note: premiums are inflated by five percent (5%) annually

- In February, it was identified that copayments on medications were being charged to Special Benefit Waiver (SBW) and Medicaid algorithm members incorrectly due to a flaw in the feed to the Pharmacy vendor. For the members who were previously charged incorrectly, the SBW Program Manager and Nurse Coordinator are assisting in the recoupment process by contacting providers and working with them to rebill affected claims so the member can be reimbursed. Maine is in the process of resolving this issue. In the meantime, the state is working to ensure that there are no negative impacts to members.

Financial/Budget Neutrality Development/Issues

Member numbers are based on distinct member paid claims of actual participation (refer to enclosure 3), as compared to the enrollment data that is based on member eligibility. Consequently, the number of members calculated in the financial shell does not match exactly to the number of members enrolled.

The figures reported in enclosures 1 and 2 ("Budget Neutrality" and "Overall Service Costs by Demonstration Year," respectively) come from the Medicaid Program Budget and Expenditure System (MBES): "CMS 64 Schedule C Report for 1115 Waivers." The data from previous quarters is updated in each enclosure with approved adjustments.

ADAP funds spent on MaineCare clients for this quarter can be seen in enclosure 4.

Member Month Reporting

Eligibility Group by Month	January 2015	February 2015	March 2015	Total for Quarter Ending 3/2015
Enrollees	454	456	459	1,369
Members	312	311	312	935

Eligibility Group by Disease Stage	1 - ASX (asymptomatic)	2 - SX (symptomatic)	3 – AIDS	Total for Quarter Ending 12/14
Enrollees	884	398	87	1,369
Members	560	279	96	935

Consumer Issues

The MaineCare Member Services help desk is the first point of contact for all MaineCare members, including those living with HIV/AIDS. Based on our monthly reports from Member Services, there were no complaints this quarter.

There were no complaints received directly by the MaineCare coordinator.

Type	Contact Note	Resolution

Quality Assurance/Monitoring Activity

- Quality indicators continue to be monitored through claims data. These indicators include cost data, number and appropriateness of anti-retroviral medications, hospitalization, physician and ER utilization rates, death rates, compliance with

guidelines on prophylactic medications for opportunistic infections, ophthalmology exams, and pap smear exams, including visits to provider offices.

- One of the waiver's primary roles is to establish a close link with provider offices in order to obtain disease progression data, including CD4 and viral load results that will allow tracking of disease state progression and targeted interventions.

- An adherence report was designed based on our members' prescription pick-up dates. A link has been established between CD4 data and the adherence report to help target interventions. Based on this report, daily calls are made to members to remind them about their prescription pick-up dates. We project that this proactive approach will improve our members' compliance with their anti-retroviral medication. There were 432 adherence calls during the quarter (refer to enclosure 5).

- Member compliance with anti-retroviral medication continues to be tracked via their prescription refills. A link has been established between CD4 data and the compliance report to help target interventions. There are three phases of calls. The first phase is of the greatest concern, where calls are made to members whose CD4 counts are below 200 and they are late picking up their medications. In the second phase, calls are made to members whose CD4 counts are between 200 and 350 and they are late picking up their medications. In the third phase, calls are made to members whose CD4 counts are above 350 and they are late picking up their medications. There were 124 compliance calls during the quarter (refer to enclosure 5).

- Frequent address changes and disconnected phones for this population continue to make it difficult to contact members for adherence and compliance interventions. Ongoing efforts continue by contacting the regional Offices for Family Independence (OFI), case managers, pharmacies, and providers for members' most updated addresses and phone numbers.

- A contact tracking system which includes calls, letters, emails, faxes, complaints, and grievances has been underway since February 6, 2003, with daily data entry by the Nurse Coordinator and Program Coordinator. This system allows us to note the number of calls per day, week, month, and year and gives us a detailed map of calls by contact entity and reason.

- A total of 1,604 contacts were made in this quarter. Phone calls were the most common mode of communication, accounting for 94% of incoming contacts and 85% of outgoing contacts. Emails were the next most common; 5% and 10% respectively (refer to enclosure 6).

- Adherence was the most common reason for contacts being made, accounting for 23% of incoming contacts and 28% of outgoing contacts (refer to enclosure 5).

Demonstration Evaluation

The HIV/AIDS Project is fully operational. Analysis of quality and cost data is continually underway. Enrollment is ongoing with 771 members included in the demonstration project at the end of the first quarter of the thirteenth year. Reports to CMS have been provided as specified in the Special Terms and Conditions.

Enclosures/Attachments

Attachment A: Outreach

Financial

Enclosure 1: Budget Neutrality Assessment
Enclosure 2: Overall Service Costs by Demonstration Year
Enclosure 3: Actual Participation by Demonstration Quarter
Enclosure 4: ADAP Funds Spent on MaineCare Clients

Communications

Enclosure 5: Contact Tracking by Reason

Enclosure 6: Contact Tracking by Method Used

State Contact

Emily Bean, Program Manager

Office of MaineCare Services

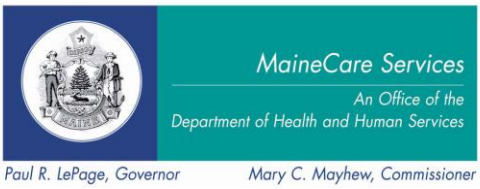
11 State House Station, Augusta, ME 04330

emily.bean@maine.gov

207-624-4005

Date submitted to CMS: May 29, 2015

Attachment A: Outreach



Department of Health and Human Services
MaineCare Services
Nurse Coordinator
11 State House Station
Augusta, Maine 04333-0011
Tel.: (207) 624-4008; Fax: (207) 287-1864
Toll Free (866) 796-2463; TTY Users: Dial 711 (Maine Relay)

January 19, 2014

Dear MaineCare Provider:

You are receiving this informational letter because you have been identified as a provider for one or more MaineCare members living with HIV. The Department of Health and Human Services has developed quality initiatives to improve care for these MaineCare members. One of these quality initiatives is to provide timely, important information to providers on certain aspects of HIV care. The Department finds it important to provide information to you, as a Primary Care Provider (PCP), because not all PCPs who see MaineCare members living with HIV are experienced in the use of anti-retroviral medication.

Enclosed, please find information from the FDA regarding HIV medication changes and alerts. For more information, please refer to the FDA's website.

Please contact Sherry Boochko, RN at 207-624-4008 if you currently have no patients with HIV.

If you have any questions, you may contact me by sending an email to kevin.flanigan@maine.gov or the Nurse Coordinator, Sherry Boochko, RN at sherry.boochko@maine.gov.

Sincerely,

Kevin Flanigan, MD
Medical Director
MaineCare Services
11 State House Station
Augusta, ME 04333-0011

On December 17, 2014, the Indications and Usage section of the STRIBILD (elvitegravir 150 mg/cobicistat 150 mg/emtricitabine 200 mg/tenofovir 300mg) label was updated to include patients who are virologically-suppressed (HIV-1 RNA <50 copies/mL) on a stable antiretroviral regimen for at least 6 months with no history of treatment failure in order to replace their current regimen. Patients should have no known substitutions associated with resistance to the individual components of STRIBILD.

The major changes to the label include the following:

Section 1: Indications and Usage update as follows:

STRIBILD® is indicated as a complete regimen for the treatment of HIV-1 infection in adult patients who have no antiretroviral treatment history or to replace the current antiretroviral regimen in those who are virologically-suppressed (HIV-1 RNA <50 copies/mL) on a stable antiretroviral regimen for at least 6 months with no history of treatment failure and no known substitutions associated with resistance to the individual components of STRIBILD

Section 5: Warnings and Precautions subsections 5.4 and 5.5 were updated as follows:

- 5.4 Avoid Use with Other Antiretroviral Products

STRIBILD is not recommended for coadministration with the following:

- cobicistat (TYBOST);
- elvitegravir (VITEKTA);
- products containing emtricitabine or tenofovir DF (ATRIPLA, COMPLERA, EMTRIVA, TRUVADA, VIREAD);
- products containing lamivudine (COMBIVIR, EPIVIR, EPIVIR-HBV, EPZICOM, TRIUMEQ, TRIZIVIR)
- adefovir dipivoxil (HEPSERA);
- products containing ritonavir (NORVIR, KALETRA)

- Addition of section 5.5 Risk of Adverse Reactions of Loss of Virologic Response Due to Drug Interactions

The concomitant use of STRIBILD and other drugs may result in known or potentially significant drug interactions, some of which may lead to:

- Loss of therapeutic effect of STRIBILD and possible development of resistance.
- Possible clinically significant adverse reactions from greater exposures of concomitant drugs.

Section 6.1- Adding the adverse reactions for those who are virologically suppressed

Section 12.4 Microbiology was updated to include information on elvitegravir, emtricitabine/tenofovir DF and elvitegravir, cobicistat, emtricitabine, and tenofovir DF

Section 14 Clinical Studies was updated to include trial result information from Study 115 and Study 121

Richard Klein
Office of Health and Constituent Affairs
Food and Drug Administration

Kimberly Struble
Division of Antiviral Products
Food and Drug Administration

Steve Morin
Office of Health and Constituent Affairs
Food and Drug Administration

On January 29, 2015, FDA approved Evotaz, a fixed dose combination tablet containing 300 mg of atazanavir and 150 mg of cobicistat. Evotaz is indicated in combination with other antiretroviral agents for the treatment of of human immunodeficiency virus (HIV 1) infection in adults.

Use of Evotaz in treatment-experienced patients should be guided by the number of baseline primary protease inhibitor resistance substitutions. The recommended dosage of Evotaz is one tablet taken once daily orally with food.

One EVOTAZ tablet provided comparable atazanavir exposures (90% confidence intervals within 80%-125%) to one atazanavir capsule (300 mg) plus one cobicistat tablet (150 mg) following single-dose administration with a light meal to healthy subjects (N=62).

Evotaz is a product of Bristol-Myers Squibb Co.

Richard Klein
Office of Health and Constituent Affairs
Food and Drug Administration

Kimberly Struble
Division of Antiviral Products
Food and Drug Administration

Steve Morin
Office of Health and Constituent Affairs
Food and Drug Administration

On January 29, 2015, FDA approved Prezcobix a fixed dose combination tablet containing 800 mg of darunavir and 150 mg of cobicistat.

Prezcobix is indicated in combination with other antiretroviral agents for the treatment of human immunodeficiency virus (HIV 1) infection in treatment-naïve and treatment-experienced adults with no darunavir resistance-associated substitutions (V11I, V32I, L33F, I47V, I50V, I54L, I54M, T74P, L76V, I84V, L89V). The recommended dosage of Prezcobix is one tablet taken once daily orally with food.

Darunavir exposure when comparing darunavir coadministered with cobicistat (as single entities) to darunavir coadministered with ritonavir was evaluated in a relative bioavailability trial in 31 healthy subjects. The results of the trial are presented in the cobicistat package insert. With the exception of Ctau, the steady-state pharmacokinetic parameters of darunavir were comparable when coadministered with cobicistat versus ritonavir and these results were similar to those reported in previous clinical trials of darunavir 800 mg with ritonavir 100 mg once daily.

The efficacy of Prezcobix is based on efficacy demonstrated in clinical trials of darunavir coadministered with ritonavir. One single arm clinical trial was conducted with darunavir and cobicistat administered as single entities in 313 HIV-infected subjects. Adverse reactions evaluated through Week 24 did not differ substantially from those reported in clinical trials with darunavir coadministered with ritonavir.

Prezcobix is a product of Janssen Pharmaceuticals.

Richard Klein
Office of Health and Constituent Affairs
Food and Drug Administration

Kimberly Struble
Division of Antiviral Products
Food and Drug Administration

Steve Morin
Office of Health and Constituent Affairs
Food and Drug Administration

On January 28, 2014 FDA approved changes to the Kaletra (lopinavir/ritonavir) label to include dosing recommendations in pregnant women. The main additions and revisions include the following:

2 DOSAGE AND ADMINISTRATION

2.4 Dosage Recommendations in Pregnancy

Administer 400/100 mg of KALETRA twice daily in pregnant patients with no documented lopinavir-associated resistance substitutions. Once daily KALETRA dosing is not recommended in pregnancy.

- There are insufficient data to recommend dosing in pregnant women with any documented lopinavir-associated resistance substitutions.
- No dosage adjustment of KALETRA is required for patients during the postpartum period.
- Avoid use of KALETRA oral solution in pregnant women.

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Pregnancy Exposure Registry

There is a pregnancy exposure registry that monitors pregnancy outcomes in women exposed to KALETRA during pregnancy. Physicians are encouraged to register patients by calling the Antiretroviral Pregnancy Registry at 1-800-258-4263.

Risk Summary

Available data from the Antiretroviral Pregnancy Registry show no difference in the risk of overall major birth defects compared to the background rate for major birth defects of 2.7% in the U.S. reference population of the Metropolitan Atlanta Congenital Defects Program (MACDP). No treatment-related malformations were observed when lopinavir in combination with ritonavir was administered to pregnant rats or rabbits; however

embryonic and fetal developmental toxicities occurred in rats administered maternally toxic doses.

Clinical Considerations

Dose Adjustments During Pregnancy and the Postpartum Period
Administer 400/100 mg of KALETRA twice daily in pregnant patients with no documented lopinavir-associated resistance substitutions [see Dosage and Administration (2.4) and Clinical Pharmacology (12.3)]. There are insufficient data to recommend KALETRA dosing for pregnant patients with any documented lopinavir-associated resistance substitutions. No dose adjustment of KALETRA is required for patients during the postpartum period.

Once daily KALETRA dosing is not recommended in pregnancy.
Avoid use of KALETRA oral solution during pregnancy due to the alcohol content. KALETRA oral solution contains the excipients alcohol (42.4% v/v) and propylene glycol (15.3% w/v).

The completed and revised label can be found at the FDAs website.

Richard Klein
Office of Health and Constituent Affairs
Food and Drug Administration

Kimberly Struble
Division of Antiviral Products
Food and Drug Administration

Steve Morin
Office of Health and Constituent Affairs
Food and Drug Administration

Department of Health and Human Services
MaineCare Services
Nurse Coordinator
11 State House Station
Augusta, Maine 04333-0011
Tel.: (207) 624-4008; Fax: (207) 287-1864
Toll Free (866) 796-2463; TTY Users: Dial 711 (Maine Relay)

Authorization to Release Information

We are committed to the privacy of your health information. Please read this form carefully.

☒ Office of Maine Care Services	❒ Substance Abuse and Mental Health Services
❒ Office for Family Independence	❒ Office of Child and Family Services
❒ Maine Centers for Disease Control and Prevention	❒ Office of Aging and Disability Services
❒ Dorothea Dix Psychiatric Center	❒ Other:
❒ Riverview Psychiatric Center	

Your Name:	Your Date of Birth: Your Social Security Number:

Your Address:

Street Town/City State Zip Code

Records to be released, including written, electronic and verbal communication:

☒ All Healthcare, including treatment, services, supplies and medicines

☒ Billing, payment, income, banking, tax, asset, and/or other information regarding financial eligibility for DHHS program benefits such as MaineCare

❒Other:_____

❒ Limit to the following date(s) or type(s) of information:
(e.g. "lab test dated June 2, 2013" or "hospital records from 1/1/12- 1/15/12")

I authorize the DHHS office(s) checked above to:
☒ Release my information to: ☒Obtain my information from:

Ryan White or named Case Management Agency: _____

Address:

_____

Street Town/City State Zip Code

Infectious Disease Specialist:_____

Address:

_____

Street Town/City State Zip Code

If requesting that electronic information be transmitted by email, please clearly print the email address bel

_____

☒ I understand that DHHS systems may not be able to send my information securely through email. I understand that email and the internet have risks that DHHS cannot control and that the information poter could be read by a third party. I accept those risks and still request that DHHS send my information by em Initials _____

Please allow the office(s) named above to disclose my information for the following purpose(s):

❒ Legal ☒Insurance ☒Coordination of Care ❒ Personal Request ❒ Other:

By initialing below, I wish for my release to include the following types of records:

_____ **Mental health treatment provider or program**
(initials)

_____ **Substance/Alcohol/drug abuse treatment provider or program**
(initials)

_____ **HIV infection status or test results:** Maine law requires us to tell you that releasing this information
(initials) may have implications. Positive implications may include giving you more complete care, and negative implications may include discrimination if the data is misused. **DHHS will protect your HIV data, and all your records, as the law requires.**

I (individual/personal representative of individual named above,) give permission to the DHHS office(s) listed above to release and/or share my records as written on this form. This form will remain in effect for one year from the date below. Other releases of my information are permitted during that time unless I revoke this form.

I further understand and agree that:

- DHHS will not condition my treatment, payment for services, or benefits on whether I sign this form, unless I need to sign this form so that the right offices of DHHS can make eligibility or enrollment decisions.

- I have the right to make a written request to access and copy my healthcare or billing information, and a copy fee will be charged as permitted by law.

- If I want a review of my mental health program or provider records before they are released, I can check here. ❒ I understand that the review will be supervised.

- I may take back my permission to share the records listed on this form at any time by contacting the Privacy Officer of the specific DHHS office: Beth Glidden 207-624-6913

- I understand that taking back my permission does not apply to the information that was already shared, as a result of my signing this form. If I revoke my permission, it may be the basis for denial of health benefits or other insurance coverage.

- I may refuse to disclose all or some health care information, but that refusal may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance, or other adverse consequences.

- DHHS offices will keep my information confidential as required by law. If I give my permission to share my records with people who are not required by law to keep them private, they may no longer be protected by confidentiality laws.

- If alcohol or drug provider or program records are included in this release, DHHS will tell the person receiving the records that they may not be shared with others who are not on this form without my written permission, unless required or permitted by law.

- I am signing this form voluntarily, and I have the right to a signed copy of this form if I request one.

Date: _____ Signature_____

Personal Representative's authority to sign: _____