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| **Division of HIV and STD Programs**  www.publichealth.lacounty.gov/aids | **Casewatch Millennium®**  **Client Consent Form** |  |

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, *(print full name)* wish to register with Ryan White Program/Casewatch Millennium**®** in order to receive services funded by the Ryan White Program or the Department of Public Health (DPH), Division of HIV and STD Programs (DHSP). During registration, I will be asked to provide information about myself, including my name, race, gender, birth date, income and other demographic data. Depending upon the agency or program I am registering with, I may also be asked questions about my CD4 cell count, viral load, use of HIV medications, risk behaviors, my general physical and medical condition and medical history.

In addition to providing information, I will provide an original letter of diagnosis signed and dated by my doctor, or have a blood test that shows that I am HIV positive. By signing this form, I verify that I reside in Los Angeles County.

I understand that certain services may be available to HIV-negative partners, family members, or other caregivers affected by HIV, and registration and service information for these clients will not be shared between agencies regardless of my own share status. I understand that my name and information will not be shared outside the Ryan White Program/Casewatch Millennium**®** system unless I provide my specific, informed consent for such a disclosure. A list of Ryan White Program/Casewatch Millennium**®** agencies is available upon request.

Additionally, as a condition of receiving Ryan White Program services, I agree that my information will be made available to my local health department, to fiscal agents that fund services I receive, to DPH/DHSP, and to the State of California Department of Public Health (CDPH), Office of AIDS, AIDS Regional Information and Evaluation System (ARIES) for mandated care and treatment reporting, program monitoring, statistical analysis and research activities. This information includes the minimum necessary, but is not limited to gender, ethnicity, birth date, zip code, diagnosis status, and service data. No identifying information, such as name and social security number, will be released, published, or used against me without my consent, except as allowed by law.

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| By checking the “I AGREE and UNDERSTAND” box below, I understand that my relevant health, including HIV status, and income information will be shared with my local health department, fiscal agents that fund services I receive, the Department of Public Health, Division of HIV and STD Programs, and the State of California Department of Public Health (CDPH), Office of AIDS, AIDS Regional Information and Evaluation System (ARIES) when I request enrollment in care or access to services at a Ryan White Program agency. Only authorized personnel at each agency will have access to my information on a need-to-know basis. The information shared may include information about services received or my treatment at a particular agency. Mental health, legal and/or substance abuse services will only be shared as allowed by law. In most cases, I will not need to re-register (in Casewatch Millennium**®)** or provide a letter of HIV diagnosis when I require services from an agency providing services funded by the Ryan White Program or the DPH/Division of HIV and STD Programs.  **I AGREE AND UNDERSTAND** |

My registration in Ryan White Program/Casewatch Millennium**®** does not guarantee services from any agency. Waiting lists or eligibility requirements may exclude me from services at other Ryan White Program/Casewatch Millennium**®** agencies.

By signing this form I acknowledge that I have been offered a copy of this consent form, and have discussed it with the staff person indicated below. I understand that this form will be stored in my paper file and that this consent form remains in effect for three (3) years from the date I sign this form.

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Signature of Client or Parent/Guardian of Minor Child Date

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| ***For Local Health Care Agency Use Only***  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *Administered By Agency Name*  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *Signature Date* |

DHSP 12-001 (Rev 6/2012)