ARIES Client Consent Form for San Francisco

I, _____ *(print full name)*, wish to register with the AIDS Regional Information and Evaluation System (ARIES) in order to receive services provided by the San Francisco Department of Public Health and/or its service providers. 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, general physical and medical condition, and medical history.

In addition to providing information, I may be asked to provide an original letter of diagnosis signed and dated by my doctor or have a blood test that shows that I am HIV-positive.

SHARE: By signing below, I choose to share my information with all other agencies I receive services from that are part of ARIES. The purposes for sharing my information in ARIES are to determine my need and eligibility for services, enroll in appropriate programs, and receive coordinated care and treatment including appropriate referrals for other services. By stating that I am willing to share my information, I will usually not need to re-register (in ARIES) or provide a letter of diagnosis when I receive services from another agency providing services funded by the Ryan White HIV/AIDS Program or the California Department of Public Health (CDPH), Office of AIDS. Only authorized personnel at an 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, alcohol/substance use, and legal information will not be shared.

As a condition of receiving services, I consent that my ARIES information may be made available to my local health department, to fiscal agents who fund the services I receive, and to the CDPH/Office of AIDS for mandated care and treatment reporting, program monitoring, statistical analysis, and research activities. This data includes, but is not limited to, demographic, financial, medical, service, mental health, alcohol/substance use, and legal information.

Additionally, as a condition of receiving services, I consent that my local health department may disclose to my health care providers the minimum necessary of my ARIES information to assist them in complying with HIV reporting laws and regulations. Mental health, alcohol/substance use, and legal information will not be disclosed for this purpose.

My registration in ARIES does not guarantee services from any other agency. Wait lists or other eligibility requirements may exclude me from services at other ARIES agencies.

By signing this form, I acknowledge that I have talked about and understand my rights to confidentiality with respect to ARIES with the staff person indicated below. I understand that this form will be stored in my paper file. This Consent remains in effect for three (3) years from the date I sign this form.

Signature of Client or Parent/Guardian of Minor Child	Date

For Local Agency Use Only

Administered By (Staff Name)	Agency Name
Signature	Date

If applicable, this client is a **NON-SHARE** client because (check all that apply):

☐ Unable to give consent ☐ Related/Affected Client ☐ HIV-Negative