AP # _____

NOLP # _____
DATE _____
PREFERRED LANGUAGE
☐ English ☐ Spanish
☐ Other: _____

APLA Health REGISTRATION FORM
MARCH 1, 2024 – FEBRUARY 28, 2025

CLIENT DEMOGRAPHIC INFORMATION

First Name _____ M.I. _____ Last Name _____ Birthdate _____

Pronoun(s) _____ Chosen Name (If different then given name) _____ Social Security Number _____
☐I do not have a Social Security Number

Sexual Orientation: _____

Birth Sex: ☐Male ☐Female ☐Other ☐Non-binary or X ☐Prefer not to state

Gender: ☐Male ☐Female ☐Trans M to F ☐Trans F to M ☐Non-Binary ☐Other

Race:
- ☐White / Caucasian
- ☐Black / African American
- ☐Native American / Alaskan
- ☐Native Hawaiian / Pacific Islander
- ☐Asian
- ☐Other (please specify) _____

Of Latino / Hispanic descent? ☐YES ☐NO

Level of Education:
- ☐None
- ☐Grades 1-8
- ☐Some High School
- ☐High School Graduate / GED
- ☐Some College / AA / Tech
- ☐Bachelor's
- ☐Master's / Doctorate

English Fluency:

Do you:

Speak English fluently?
☐YES ☐NO

Read and write in English?
☐YES ☐NO

MAIL/HOME ADDRESS

Home Address
Street Address _____ Apt/Unit # _____
City _____ State _____ Zip Code _____

Mailing Address
Complete if different than home address
Street Address _____ Apt/Unit # _____
City _____ State _____ Zip Code _____

Is it OK to send mail from APLA Health to your:

Home Address ☐Yes ☐No **Mailing Address** ☐Yes ☐No

Do you live, work or go to school in West Hollywood?: ☐Yes ☐No

CURRENT LIVING SITUATION

- ☐ Rental (apartment, home, or room)
- ☐ Client-Owned Housing
- ☐ Emergency Shelter (motel voucher)
- ☐ Transitional Housing for Homeless
- ☐ Substance Abuse or Psychiatric Facility
- ☐ Other (please specify) _____

Do you have any dependents? ☐YES ☐NO

- ☐Staying with family / friend (no rent)
- ☐Homeless (street, car, bus)
- ☐Hotel / Motel (not paid by voucher)
- ☐Permanent Housing (Shelter+Care, SRO)
- ☐Jail / Prison / Juvenile Facility

Number of Bedrooms: _____

Number of Legal Dependents: _____

COMMUNICATION PREFERENCES

Daytime Phone:

_____ **May we leave a message indicating a call is from APLA Health?** ☐YES ☐NO

Evening Phone (If different than daytime phone):

_____ **May we leave a message indicating a call is from APLA Health?** ☐YES ☐NO

Mobile Phone (If different than daytime phone):

_____ **May we leave a message indicating a call is from APLA Health?** ☐YES ☐NO

_____ **May we contact you by e-mail?** ☐YES ☐NO

E-mail **(cannot guarantee privacy)**

CLIENT HISTORY and MARITAL STATUS

Jail/Prison History

- ☐ None
- ☐ Jail / prison within the past 6 months
- ☐ Jail / prison within the past 2 years
- ☐ Jail / prison over 2 years ago

Date of First Diagnosis: ☐Unknown date of first diagnosis

_____

Gender(s) of your sexual partner(s)? (Check all that apply)

- ☐Male
- ☐Female
- ☐No sexual partners
- ☐Transgender Male
- ☐Transgender Female

Marital Status

- ☐Single
- ☐Separated/Divorced
- ☐Partnered/Not Legally Married
- ☐Married/Domestic Partner _____ years
- ☐Widowed _____ years

CLIENT SOURCE(S) OF MEDICAL INSURANCE

Current Primary Insurance Provider

- ☐Medi-Cal without share cost
- ☐Medi-Cal with share cost
- ☐Medicare
- ☐HMO/PPO
- ☐Private
- ☐VA and/or other government benefits
- ☐None
- ☐Unknown
- ☐Other Public
- ☐Both Medi-Cal and Medicare
- ☐Other (please specify) _____

Do you currently receive AIDS Drug Assistance Program (ADAP) benefits? ☐YES ☐NO

Have you applied for Medi-Cal benefits recently? ☐Yes ☐No What is the date of application _____

What is the status of your application? _____

HMO/PPO carrier name: _____ Insurance ID# _____ Eligibility date _____

How much is your medical visit co-pay? $_____ How much is your prescription co-pay? $_____

Where do you primarily receive medical care? _____

Healthcare Physician/Nurse name _____ Phone Number _____

Case Manager/Social Worker name _____ Phone Number _____

Are you satisfied with your medical care? ☐Yes ☐No

MONTHLY INCOME

Type of Income	Monthly Amount	Type of Income	Monthly Amount
Social Security Disability Insurance (SSDI)	$_____	Employed	$_____
Supplemental Security Income (SSI)	$_____	Self-Employed	$_____
State Disability Insurance (SDI)	$_____	Private Disability Insurance	$_____
Unemployment Insurance (UA)	$_____	Retirement/Pension	$_____
Child Support and/or Alimony	$_____	Worker's Compensation	$_____
General Relief (GR)	$_____	Cal-Fresh (Food Stamps)	$_____
CalWORKs (TANF)	$_____	Support of Family/Friends	$_____
Veterans Benefits (VA)	$_____	Investment Income	$_____
		Other	$_____

Total Monthly Income $ _____

EMERGENCY CONTACT ☐ Decline to Provide

Emergency Contact Name _____ **Relationship to client** _____ **Aware of HIV status?** ☐YES ☐NO

Daytime Phone _____ **Preferred Language:** ☐ English ☐ Spanish

Evening Phone _____ ☐ Other_____ **OK to disclose?** ☐YES ☐NO

Mobile Phone _____

Emergency Contact Street Address _____ **Apt/Unit #** _____

City _____ **State** _____ **Zip Code** _____

DPA

Durable Power of Attorney Name _____ **Durable Power of Attorney Phone** _____

ADDITIONAL CONTACT

If someone else were to answer your phone, who could APLA Health leave a message or speak with?

Name _____ **Relationship to client** _____ What is your household size (how many people live with you): _____

Name _____ **Relationship to client** _____

CLIENT HISTORY

Are you a veteran?	☐ Yes	☐ No
Are you chronically homeless/un-housed?	☐ Yes	☐ No
Are you a domestic violence survivor?	☐ Yes	☐ No

My signature below indicates my understanding and certification of:

- **HIPAA Patient Consent Form** (attached, page 4)
- **Consent to Release Medical Information** (attached, page 4)
- **Client Grievance Procedures** (attached, page 5)
- **Patient and Client Bill of Rights and Responsibilities** (attached, page 5-7)
- **Client Services Agreement** (attached, page 8)
- **Casewatch Millennium Client Share/Non-Share Consent Form** (attached, page 9)
- **Consent to Release Medical Information Signature** (attached, page 10)
- **Consent to Release Information Procedures** (attached, page 10)

Client Print Name _____ **Date** _____

Signature of Client or Parent/Guardian of Minor _____ **Date** _____

STAFF ONLY (BELOW THIS LINE)

==========

Administered By (Staff Print Name) _____ **Agency Name** _____

Signature of Staff _____ **Date** _____

HIPAA PATIENT CONSENT FORM

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established a "Privacy Rule" to help ensure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain a patient consent to disclose health information about the patient in order to carry out treatment, payment, or health care operations.

APLA Health wants you to know that we respect the privacy of your personal health information and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate or necessary, we provide only the minimum necessary information to those we feel are in need of your health care information regarding treatment, payment or health care operations, in order to provide health care that is in your best interest.

We fully support your access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with the physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. This includes instances where you are a threat to yourself (suicide or homicide ideation) or instances of child or elder abuse. As part of this plan, we have implemented a Compliance Program that oversees the prevention of any inappropriate use of Personal Health Information. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be done in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information. If you choose to give consent in this document. at some future time you may request to refuse all or part of your Personal Health Information. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form. please ask to speak with our HIPAA Compliance Officer. You have the right to review our Privacy Notice (Compliance Assurance Notification to Our Patients), to request restrictions, and revoke consent in writing.

CONSENT TO RELEASE MEDICAL INFORMATION

Your health and medical information is considered sensitive and private and is afforded protection under the law. APLA Health will make every effort to keep all client records secure. However, as a client of APLA Health there are circumstances that will require the exchange of information about me through phone, faxing, e-mailing, and mailing.

I understand that APLA Health will represent me in these exchanges, and that APLA Health cannot be held responsible if any person becomes aware that I am a client at APLA Health.

CLIENT GRIEVANCE PROCEDURES

Policy

APLA Health has established a Client Bill of Rights to ensure that clients are treated with respect and are provided the highest possible quality of services. The grievance policy has been adopted for a client to utilize if he/she feels one of his/her rights, as defined in the Client Bill of Rights, was violated or if he/she has a specific grievance that needs to be addressed.

Procedures

1. If a client has a grievance with a program or with the staff of a program, the client should first try to resolve the matter with the supervisor or program management
2. If resolution is not achieved after speaking with the supervisor or the program manager. then the client should contact the division director.
3. The supervisor, program manager, and division director will listen to the information about the incident and will attempt to mediate the grievance.
4. Any grievance that is the result of a dispute over a written service agreement between a client and a manager of a specific program will be examined by the division director to determine if the service agreement was fair. and if the service agreement was in fact violated by the client.
5. If the matter cannot be mediated, it will be turned over to the division director for final resolution.
6. Grievances will receive prompt attention. Every effort will be made by all appropriate staff to address and resolve grievances within ten (10) working days.
7. If you believe your grievance has not been resolved, you may contact the Los Angeles Division of HTV and STD Programs at 1.800 260.8787

PATIENT AND CLIENT BILL OF RIGHTS AND RESPONSIBILITIES

The purpose of this Patient and Client Bill of Rights is to help enable clients act on their own behalf and in partnership with their providers to obtain the best possible HIV/AIDS care and treatment. This Bill of Rights and Responsibilities comes from the hearts of people living with HIV/AIDS in the diverse communities of Los Angeles County. As someone newly entering or currently accessing care, treatment, or support services for HIV/AIDS, you have the right to:

A. **Respectful Treatment**

1. Receive considerate, respectful, professional, confidential, and timely care in a safe, client-centered environment without bias.
2. Receive equal and unbiased care in accordance with federal and state law.
3. Receive information about the qualifications of your providers, particularly about their experience managing and treating HIV/AIDS or related conditions.
4. Be informed of the names and work phone numbers of the physicians, nurses, and other staff members responsible for your care.
5. Receive safe accommodations for protection of personal property while receiving care and services.
6. Receive services that are culturally and linguistically appropriate, including having full explanations of all services and treatment options provided clearly in your own language and dialect.
7. Look at your medical records and receive copies of them upon your request (reasonable agency policies including reasonable fee for photocopying may apply)
8. When special needs arise, extended visiting hours by family, partier, or friends during inpatient treatment, recognizing that there may be limits imposed for valid reasons by the hospital, hospice, or other inpatient institution.

B. **Competent, High-Quality Care**

1. Have your care provided by competent, qualified professionals who follow HIV treatment standards as set forth by the Federal Public Health Service Guidelines, the Centers for Disease Control and Prevention (CDC), the California Department of Health Services, and the County of Los Angeles.
2. Have access to these professionals at convenient times and locations.
3. Receive appropriate referrals to other medical, mental health, or other care services.

C. Make Treatment Decisions

1. Receive complete and up-to-date information in words you understand about your diagnosis, treatment options, medications (including common side-effects and complications), and prognosis that can reasonably be expected.
2. Participate actively with your provider(s) in discussions about choices and options available for your treatment.
3. Make the final decision about which choice and option is best for you after you have been given all relevant information about these choices and the clear recommendation of your provider.
4. Refuse any and all treatments recommended and be told of the effect not taking the treatment may have on your health, be told of any other potential consequences of your refusal, and be assured that you have the right to change your mind later.
5. Be informed about and afforded the opportunity to participate in any appropriate clinical research studies for which you are eligible.
6. Refuse to participate in research without prejudice or penalty of any sort.
7. Refuse any offered services or end participation in any program without bias or impact on your care.
8. Be informed of the procedures at the agency or institution for resolving misunderstandings, making complaints, or filing grievances.
9. Receive a response to any complaint or grievance within 30 days of filing it.
10. Be informed of independent ombudsman or advocacy services outside the agency to help you resolve problems or grievances (see phone number at bottom of this form), including how to access a federal complaint center within the Center for Medicare and Medicaid Services (CMS).

D. Confidentiality and Privacy

1. Receive a copy of your agency's Notice of Privacy Policies and Procedures. Your agency will ask you to acknowledge receipt of this document.
2. Keep your HIV status confidential or anonymous with respect to HIV counseling and testing services. Have information explained to you about confidentiality policies and under what conditions, if any, information about HIV care services may be released.
3. Request restricted access to specific sections of your medical records.
4. Authorize or withdraw requests for your medical record from anyone else besides your health care providers and for billing purposes.
5. Question information in your medical chart and make a written request to change specific documented information. Your physician has the right to accept of refuse your request with an explanation.

E. Billing Information and Assistance

1. Receive complete information and explanation in advance of all charges that may be incurred for receiving care, treatment, and services as well as payment policies of your provider.
2. Receive information on any programs to help you pay and assistance in accessing such assistance and any other benefits for which you may be eligible.

F. Patient/Client Responsibilities

In order to help your provider give you and other clients the care to which you are entitled, you also have the responsibility to:

1. Participate in the development and implementation of your individual treatment or service plan to the extent that you are able.
2. Provide your providers, to the best of your knowledge, accurate and complete information about your current and past health and illness, medications and other treatment and services you are receiving, since all of these may affect your care. Communicate promptly in the future any changes or new developments.
3. Communicate to your provider whenever you do not understand and information you are given.
4. Follow the treatment plan you have agreed to and/or accept the consequences of not following the recommended course of treatment or of using other treatments.
5. Keep your appointments and commitments at this agency or inform the agency promptly if you cannot do so.
6. Keep your provider or main contact informed about how to reach you confidentially by phone, mail, or other means.
7. Follow the agency's rules and regulations concerning patient/client care and conduct.
8. Be considerate of your providers and fellow clients/patients and treat them with the respect you yourself expect.
9. The use of profanity or abusive or hostile language; threats, violence or intimidation; carrying weapons of any sort; theft or vandalism; intoxication or use of illegal drugs, and sexual harassment or misconduct is strictly prohibited.
10. Maintain the confidentiality of everyone else receiving care or services at the agency by never mentioning to anyone who you see here or casually speaking to other clients not already know to you if you see them elsewhere.

For More Help or Information

Your first step in getting more information or resolving any complaints or grievances should be to speak with you provider or a designated client services representative or patient or treatment advocate at the agency. If this does not resolve any problem in a reasonable time span, or if serious concerns or issues that arise that you feel you need to speak about with someone outside the agency, you may call the number below for confidential, independent information and assistance.

For patient and complaints/grievances call (800) 260-8787
8:00 am - 5:00 pm
Monday-Friday

THE CLIENT SERVICES AGREEMENT – How the Program Works

NOLP is a supplemental food assistance and nutrition education program designed to serve qualifying low-income individuals living with HIV / AIDS in Los Angeles County.

ELIGIBILTY GUIDELINES

To receive food assistance through NOLP, the following documents are required. ***NOTE: All documentation must be dated between March 1, 2024 - February 28, 2025.***

1. **Photo Identification**
2. Completion of the **NOLP Enrollment**
3. Proof of **Income or Affidavit**
4. Proof of **Residency or Affidavit**
5. **Nutrition Options:** Complete quick nutrition document; attend a nutrition class; or meet one on one with one of our dietitians.
6. **Proof of HIV (New Clients Only):** letter signed by a physician or diagnosis form containing a physician or licensed healthcare provider (Nurse Practitioner or Physician Assistant) signature or laboratory results containing the name of the laboratory and indicating HIV status, CD4 count, HIV viral load, and type of HIV viral load test performed (within last 12 months), or two (2) rapid testing algorithm (RTA) results in which both tests contain positive results. Both tests should indicate the agency name, HIV counselor name, and the client's name. **(Only necessary if enrolling for the first time.)**

NOLP Card

Once enrolled you will be issued a NOLP card, which is an identification card that each client uses to access the program. Upon pick up, you will need to show your NOLP Card or a picture I.D. If you are unable to shop, you can send a friend in your absence. Your substitute shopper will need a note from you stating that he's able to shop in your absence as well as your NOLP Card.

Program Access

Present your card to the NOLP staff member. Sign the sign in sheet and voucher. NOLP clients are allowed to pick up groceries once a week. During your visits, you will receive a variety of items such as: fresh produce, canned goods, pasta, rice, dry beans, frozen meats, beverages, snacks, hygiene and cleaning supplies.

Grievance Procedures

If a client has a grievance with the program, staff, or volunteer of the program, the client should try to resolve the matter with the Site Coordinator. If a solution is not reached, contact the program's Administrative Coordinator. If a solution is still not reached, the client should contact the Program Manager. If you have questions or concerns please call 213.201.1433.

Termination

APLA reserves the right to suspend/terminate a client's shopping privileges if there is evidence of abuse or misuse (e.g., theft, reselling NOLP food, inappropriate behavior which includes bringing a weapon of any kind, and using alcohol/drugs or being under the influence of alcohol/ drugs at a distribution site). Verbal abuse, physical violence or threats to staff, volunteers, trainees, contractors or other clients are cause for immediate termination of NOLP services.

Fee Determination

All food and nutrition education services provided through the APLA Health Vance North Necessities of Life Program are free.

NOLP Locations and Hours

Koreatown
David Geffen Health Center
611. S Kingsley Dr.
Los Angeles, CA 90005
Every **Wednesday** & **Friday** from
10:00 AM - 12:00 PM &
1:30 PM - 5:30 PM
* Closed 1st Friday of the month

West Hollywood
Michael Gottlieb Health Center
7531 Santa Monica Blvd.
West Hollywood, CA 90046
Every **Saturday** from
12:00 PM - 3:00 PM

Pasadena
Wesley Health Centers
1845 N. Fair Oaks. G-125,
Pasadena, CA 91103
Every **Friday** from
9:00 AM - 12:00 PM &
1:00 PM - 3:00 PM

Lancaster
Wesley Health Centers
45104 10th Street West
Lancaster, CA 93534
Every **Thursday** from
9:00 AM - 12:00 PM &
1:00 PM - 3:00 PM

San Fernando Valley
Vance North NOLP
7336 Bellaire Ave
North Hollywood, CA 91605
Every **Thursday** from
10:00 AM - 4:30 PM
*Every 3rd Thursday from
10:00 AM - 3:00 PM

Claremont
Foothill AIDS Project
678 S. Indian Hill Blvd. Suite 220,
Claremont, CA 91711
The **2nd** & **4th Wednesday** of
the month from
2:00 PM - 4:00 PM

Long Beach
AIDS Food Store
590 E. Willow St. Long
Beach, CA 90806
Every **Tuesday** from
9:00 AM - 2:00 PM

South Los Angeles
APLA Health Center
1679 E. 120th St.
Los Angeles, CA 90059
Every **Thursday** from
10:00 AM - 12:00 PM &
1:30 PM - 4:00 PM
* Every 3rd Thursday from 10:00 AM -
12:00 PM & 1:30PM - 3:00 PM

East Hollywood
Wesley Health Centers
954 N. Vermont Ave.
Los Angeles, CA 90029
Every **Wednesday** from
9:00 AM - 12:00 PM &
1:00 PM - 3:00 PM

Community partners distribute NOLP in Skid Row, Reseda, Venice, and Santa Monica. Please call 213.201.1433 for information on accessing those sites.

Casewatch Millennium®
Client Share/Non-Share Consent Form

I 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 (DHP), 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.

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.

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.

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.

Consent to Release Medical Information

Signing this Consent to Release Medical Information allows you the flexibility to determine what types of information are to be released and under what circumstances. In addition, this form complies with the HIPAA (Health Insurance Portability and Accountability Act) Privacy Rules.

I _____ hereby authorize _____

Name of Client **Name of Doctor or Medical Group**

to give information from my record with no limitations on the date of illness, history of illness, diagnosis, or therapeutic information to APLA Health for the purpose of verification of diagnosis and/or providing or referring for dental treatment and/or nutritional counseling. I understand that this authorization may be revoked at any time, except to the extent that the action has already occurred.

Consent to Release Information Procedures

I _____ hereby authorize staff from AIDS Healthcare Foundation (AHF), APLA Health, Asian Pacific AIDS Intervention Team, City of Pasadena, Andrew Escajeda Clinic, ALTAMED Health Service Corp, Automated Case Management Systems (ACMS), Being Alive, Children's Hospital, Division of Adolescent Medicine. Bienestar, Cedars Sinai. Central City Clinic, City of Long Beach -AIDS Program, East Valley Community Health Center, El Proyecto del Barrio, Foothill AIDS Project, Greater Los Angeles Council on Deafness, Harbor/UCLA Medical Center, High Desert Health System, Hubert Humphrey, JWCH Institute, Inc., Kaiser Permanente, LAC-USC (5p21, Maternal Child/Adolescent, EIP, Weingart). L.A. Gay &e Lesbian Center, Memorial Miller Children's Hospital, Minority AIDS Project. Northeast Valley Health Corporation, Division of HIV & STD Programs, Olive View Medical Center. Pathways, Project Angel Food, South Bay Family Healthcare Center, Spectrum, St. Mary Medical Center CARE Program & Clinics, Tarzana Treatment Center, T.H.E. Clinic. Inc. (To Help Everyone), UCLA Care, Valley Community Clinic, Venice Family Clinic, Watts Healthcare to release, receive, and share information regarding services, and to share information through the mail, telephone, fax, or electronic computer mail. etc., regarding my HIV test results: HIV status: physical, mental or financial condition; or services received related to my need for current or future assistance at the above agencies.

This consent is valid from the date it is signed and may be revoked at any time by signing under the cancellation statement below or by verbally informing the agency holding this original form. I understand that I may add other specific agencies and individuals to this form by listing them and signing below.

_____ _____ _____

Signature of Client or Parent/Guardian of Minor **Today's Date** **Consent valid through:**

I wish to **add** the following specific individuals, agencies and/or physicians to this Consent to Release Medical Information:

_____

_____

_____ _____

Signature of Client or Parent/Guardian of Minor **Date**