



# APLA Health Registration Form

Date: \_\_\_\_\_

e2LA ID# \_\_\_\_\_

Salesforce #: \_\_\_\_\_

<b>CLIENT CONTACT INFORMATION</b>	<p>_____ <b>First Name</b></p>				<p>_____ <b>M.I.</b></p>	<p>_____ <b>Last Name</b></p>		<p>_____ <b>Birthdate</b></p>		
	<p>_____ <b>Pronoun(s)</b></p>			<p>_____ <b>Preferred Name</b></p>			<p>_____ <b>Social Security Number</b></p>			
	<p>_____ <b>Mother's Family Name</b></p>									
	<p><b>Home Address</b></p> <p>If homeless, please provide Zip Code of area where you stay.</p>									
	<p>_____ <b>Street Address</b></p>								<p>_____ <b>Apt/Unit #</b></p>	
	<p>_____ <b>City</b></p>			<p>_____ <b>State</b></p>		<p>_____ <b>Zip Code</b></p>				
<p><b>Mailing Address</b></p> <p>Complete if different than home address</p>										
<p>_____ <b>Street Address</b></p>								<p>_____ <b>Apt/Unit #</b></p>		
<p>_____ <b>City</b></p>			<p>_____ <b>State</b></p>		<p>_____ <b>Zip Code</b></p>					
<p><b>Is it OK to send mail from APLA Health to you?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Home Address</b> <input type="checkbox"/> Yes <input type="checkbox"/> No    <b>Mailing Address</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p>										
<p><b>Do you live in West Hollywood?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No    <b>Do you go to school in West Hollywood?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Do you work in West Hollywood?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p>										
<p><b>Daytime Phone:</b></p> <p>_____ <b>May we leave a message indicating a call is from APLA Health?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p>										
<p><b>Mobile Phone:</b></p> <p>_____ <b>May we leave a message indicating a call is from APLA Health?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p>										
<b>EMERGENCY CONTACT</b>	<p>_____ <b>Emergency Contact Name</b></p>				<p>_____ <b>Relationship to client</b></p>			<p><b>Preferred Language:</b></p> <p><input type="checkbox"/> English</p> <p><input type="checkbox"/> Spanish</p> <p><input type="checkbox"/> Other _____</p>		<p><b>Aware of HIV status?</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
	<p><b>OK to disclose?</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>									
	<p>_____ <b>Mobile Phone</b></p>				<p>_____ <b>Additional Phone</b></p>					
	<p>_____ <b>Emergency Contact Street Address</b></p>				<p>_____ <b>City</b></p>		<p>_____ <b>State</b></p>		<p>_____ <b>Zip Code</b></p>	
<b>DPA</b>	<p>_____ <b>Durable Power of Attorney Name</b></p>				<p>_____ <b>Durable Power of Attorney Phone</b></p>					

<b>DEMOGRAPHIC INFORMATION</b>	<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Trans M to F <input type="checkbox"/> Trans F to M <input type="checkbox"/> Non-Binary <input type="checkbox"/> Other <b>Birth Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Non-binary or X <b>Sexual Orientation:</b> <input type="checkbox"/> Gay <input type="checkbox"/> Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Pansexual <input type="checkbox"/> Other _____																																										
	<b>Race</b> <input type="checkbox"/> White / Caucasian <input type="checkbox"/> Black / African American <input type="checkbox"/> Hispanic / Latino <input type="checkbox"/> Native American / Alaskan <input type="checkbox"/> Native Hawaiian / Pacific Islander <input type="checkbox"/> Asian Please specify: _____	<b>Level of Education</b> <input type="checkbox"/> None <input type="checkbox"/> Grades 1-8 <input type="checkbox"/> Some High School <input type="checkbox"/> High School Graduate / GED <input type="checkbox"/> Some College / AA / Tech <input type="checkbox"/> Bachelor's <input type="checkbox"/> Master's / Doctorate	<b>Birth Country Name</b> _____  <b>First HIV Diagnosis Date</b> _____																																								
<b>CURRENT HOUSING SITUATION</b>	<b>Household size</b> _____ <input type="checkbox"/> Permanent Housing <input type="checkbox"/> Staying with family or friend <input type="checkbox"/> Transitional Housing <input type="checkbox"/> Homeless (street, car, park) <input type="checkbox"/> Emergency Shelter <input type="checkbox"/> Hotel / Motel <input type="checkbox"/> Substance Abuse or Psychiatric Facility <input type="checkbox"/> Other (please specify) _____ Are you chronically homeless/un-housed? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you a veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you a domestic violence survivor? <input type="checkbox"/> Yes <input type="checkbox"/> No																																										
<b>HIV HISTORY</b>	<b>Primary HIV Exposure</b> <input type="checkbox"/> Sex with Men <input type="checkbox"/> Sex with Women <input type="checkbox"/> Injection Drug use <input type="checkbox"/> Blood Transfusion <input type="checkbox"/> Perinatal Transmission																																										
<b>SOURCE OF INCOME</b>	<table style="width: 100%; border: none;"> <thead> <tr> <th style="text-align: center; border: none;"><u>Type of Income</u></th> <th style="text-align: center; border: none;"><u>Monthly Amount</u></th> <th style="text-align: center; border: none;"><u>Type of Income</u></th> <th style="text-align: center; border: none;"><u>Monthly Amount</u></th> </tr> </thead> <tbody> <tr> <td style="border: none;">Social Security Disability Insurance (SSDI) \$</td> <td style="border: none;">_____</td> <td style="border: none;">Employed \$</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;">Supplemental Security Income (SSI) \$</td> <td style="border: none;">_____</td> <td style="border: none;">Self-Employed \$</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;">State Disability Insurance (SDI) \$</td> <td style="border: none;">_____</td> <td style="border: none;">Private Disability Insurance \$</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;">Unemployment Insurance (UA) \$</td> <td style="border: none;">_____</td> <td style="border: none;">Retirement/Pension \$</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;">Child Support and/or Alimony \$</td> <td style="border: none;">_____</td> <td style="border: none;">Worker's Compensation \$</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;">General Relief (GR) \$</td> <td style="border: none;">_____</td> <td style="border: none;">Cal-Fresh (Food Stamps) \$</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;">CalWORKs (TANF) \$</td> <td style="border: none;">_____</td> <td style="border: none;">Support of Family/Friends \$</td> <td style="border: none;">_____</td> </tr> <tr> <td style="border: none;">Veterans Benefits (VA) \$</td> <td style="border: none;">_____</td> <td style="border: none;">Investment Income/Other \$</td> <td style="border: none;">_____</td> </tr> <tr> <td colspan="4" style="text-align: center; border: none;"><b>Total Income \$</b> _____</td> </tr> </tbody> </table>			<u>Type of Income</u>	<u>Monthly Amount</u>	<u>Type of Income</u>	<u>Monthly Amount</u>	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 \$	_____	<b>Total Income \$</b> _____			
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<b>CLIENT HISTORY</b>	<b><u>Jail / Prison History</u></b> <input type="checkbox"/> None <input type="checkbox"/> Jail / prison within the past 6 months <input type="checkbox"/> Jail / prison within the past 2 years <input type="checkbox"/> Jail / prison over 2 years ago	<b>Gender(s) of your sexual partner(s)?</b> (Check all that apply) <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> No sexual partners <input type="checkbox"/> Transgender Male <input type="checkbox"/> Transgender Female	<b><u>Marital Status</u></b> <input type="checkbox"/> Single <input type="checkbox"/> Separated / Divorced <input type="checkbox"/> Partnered / Not Legally Married <input type="checkbox"/> Married / Domestic Partner <input type="checkbox"/> Widowed																																								

**Insurance Information**

- Medi-Cal without share cost
- Medi-Cal with share cost
- Medicare
- Medi-Cal & Medicare
- HMO/PPO Private Insurance
- VA and / or other government benefits
- Other (please specify): \_\_\_\_\_
- No Insurance

Are you currently enrolled in AIDS Drug Assistance Program (ADAP)?  Yes  No

Have you applied for Medi-Cal benefits recently?  Yes  No

What is the date of application for Medi-Cal benefits? \_\_\_\_\_

What is the status of your application? \_\_\_\_\_

Insurance ID#: \_\_\_\_\_ Eligibility date: \_\_\_\_\_

**Primary Physician or Medical Provider**

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 Do you need a medical referral?  Yes  No

**Please check all that apply to you:**

- Physically disabled
- Blind or partially sighted
- Deaf or hard of hearing

**I hereby certify that the information I provided is true and accurate to the best of knowledge.**

\_\_\_\_\_  
**Client Print Name**

\_\_\_\_\_  
**Signature of Client**

\_\_\_\_\_  
**Date**

**APLA Health STAFF ONLY (BELOW THIS LINE)**

\_\_\_\_\_  
**Administered By (Staff Print Name)**

\_\_\_\_\_  
**Signature of Staff**

\_\_\_\_\_  
**APLA Health**

\_\_\_\_\_  
**Agency Name**

\_\_\_\_\_  
**Date**

**PRIMARY CARE & MEDICAL INSURANCE**



## **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.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

## **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 HIV and STD Programs at 1.800.260.8787

\_\_\_\_ (Initial) *I agree and understand the statement above and I agree with its terms & conditions.*

## **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, partner, 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.

\_\_\_\_ (Initial) *I agree and understand the statement above and I agree with its terms & conditions.*

### **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.  
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**

10. Receive a copy of your agency's Notice of Privacy Policies and Procedures. Your agency will ask you to acknowledge receipt of this document.
11. 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.
12. Request restricted access to specific sections of your medical records.
13. Authorize or withdraw requests for your medical record from anyone else besides your health care providers and for billing purposes.
14. Question information in your medical chart and make a written request to change specific documented information. Your physician has the right to accept or 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.

\_\_\_\_ (Initial) **I agree and understand the statement above and I agree with its terms & conditions.**

## **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.

\_\_\_\_ (Initial) **I agree and understand the statement above and I agree with its terms & conditions.**



## e2 Los Angeles County Ryan White Program Client Consent Form

I, \_\_\_\_\_, (*print full name*) wish to register with the e2 Los Angeles County Ryan White Program ("e2LA") in order to receive services funded by the Los Angeles County Department of Public Health, Division of HIV and STD Programs (DHSP). During registration, I will be asked to provide information about myself, including my name, birth date, address, and other demographic data.

As a condition of receiving services, I agree that my information will be made available to DHSP, to fiscal agents that fund services I receive, and to the State of California Department of Public Health, Office of AIDS, HIV Care Connection system for mandated reporting, program monitoring, and statistical analysis. No identifying information, such as name, birth date, and social security number, will be released, published, or used about me without my consent, except as allowed by law.

By checking the "I AGREE and UNDERSTAND" box below, I am consenting to and understand that my relevant health information will be stored in the e2 Los Angeles County system ("e2LA") and shared with DHSP and fiscal agents that fund services I receive, and to the State of California Department of Public Health, Office of AIDS, HIV Care Connection system.

Other DHSP funded agencies providing HIV and STD services may have access to my health information in e2LA, but only to assist with my care and reduce unnecessary paperwork. As such, I may not need to re-register for e2LA when I receive services from another agency funded by DHSP.

I also understand that information about the receipt of mental health, legal and/or substance use disorder services will be more restricted and only be shared as allowed by law.

**I AGREE AND UNDERSTAND**

My registration in e2LA does not guarantee services from any agency. Waiting lists or eligibility requirements may exclude me from services at other e2LA agencies.

By signing this form, I acknowledge that I have been offered a copy of this Client Consent Form and have discussed it with the staff person indicated below. I understand that this form will be stored in my file and that this form 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 Health Care Agency Use Only***

\_\_\_\_\_  
*Administered By*

APLA Health  
\_\_\_\_\_  
*Agency Name*

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*



## 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.

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 AIDS Project Los Angeles 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, \_\_\_\_\_, 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 & 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.

X \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Signature of Client Date Consent Valid Through (DD/MM/YY)

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

\_\_\_\_\_

X \_\_\_\_\_  
Signature of Client Date