



ARIES Client Share/Non-Share Consent Form



I, _____, (*print full name*) wish to register with ARIES in order to receive services funded by the Ryan White CARE Act or the California Department of Public Health (CDPH), Office of AIDS. During registration, I will be asked to provide information about myself, including my name, race, gender, date of birth 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, my general physical and medical condition and other medical history questions.

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. I understand that I will also need to answer questions about my income. By signing this form, I state that I live in the California County I am seeking services from, or intend to reside there.

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.

<p>SHARE: By checking the “share” box below, I choose to share my registration information with other agencies I receive services from that are part of ARIES. 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, legal and/or substance abuse services will only be shared as allowed by law. 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 require services from an agency providing services funded by the Ryan White CARE Act or the CDPH/Office of AIDS.</p> <p>NON-SHARE: By checking the “non-share” box below, I choose not to share my information with ARIES agencies that I go to for services. If I do not want my information shared between ARIES agencies, I will provide all ARIES registration and other information, including an original letter of diagnosis, to each agency that I go to for services.</p> <p style="text-align: center;">I choose: <input type="checkbox"/> Share <input type="checkbox"/> Non-Share</p>
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I can change my decision about sharing/not sharing by informing the staff at any agency where I go for service and by signing a new ARIES Client Share/Non-Share Consent Form. I understand that changing from Non-Share to Share opens my ARIES record to other ARIES agencies I receive services from. No matter what I choose, my name and information will not be shared outside the ARIES system unless I provide my specific, informed consent to such a disclosure.

Regardless of my share/non-share status, I understand that the information I provide 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 requirements, and may be used for program monitoring, statistical analysis and research activities. This information includes, 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/or to ensure compliance with policy.

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 been offered a copy of the Share/Non-Share Consent Form and have talked about and understand the choices of sharing or not sharing with the staff person indicated below. I understand that this form will be stored in my paper file.

Signature of Client or Parent/Guardian of Minor Child

Date

For Local Health Care Agency Use Only

Administered By

Agency Name

Signature

Date