ARIES OA-HIPP/OA-PCIP Client Consent Form

I, ______________________________ *(print full name),* wish to register with the AIDS Regional Information and Evaluation System (ARIES) in order to receive services provided by the California Department of Public Health (CDPH) / Office of AIDS (OA) Health Insurance Premium Payment Program (OA-HIPP) or the OA-Pre-Existing Condition Insurance Plan Program (OA-PCIP). During registration, I will be asked to provide information about myself, including my name, race, gender, date of birth, HIV disease stage and other demographic data.

In addition to providing the above information, I must provide this form along with other program forms and documentation required by OA-HIPP/OA-PCIP. This ARIES OA-HIPP/OA-PCIP Client Consent Form is in addition to a county's or agency's ARIES Client Consent Form used to register for other (non-insurance premium payment) HIV programs or services.

SHARE: By signing below, I understand my registration information and OA-HIPP/OA-PCIP services will be shared 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. If I receive other, non-insurance services at another ARIES agency, information about those services or treatments received will also be shared with the other ARIES-using agencies that I receive services from. Mental health, alcohol/substance use, and legal information will not be shared. By stating that my information will be shared, I will usually not need to re-register (in ARIES) or provide a letter of diagnosis when I require assistance from another agency providing services funded by the Ryan White HIV/AIDS Program or the California Department of Public Health/Office of AIDS. An ARIES Consent Form will be completed again as part of the annual OA-HIPP/OA-PCIP re-enrollment process; if no re-enrollment occurs, Consent will expire two years from the date I sign this form.

I understand that the information I provide may be made available to my local health department and to the CDPH/OA 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.

Additionally, as a condition of receiving insurance premium 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.

My registration in ARIES does not guarantee services from any other ARIES-using 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 ARIES OA-HIPP/OA-PCIP Client Consent Form and 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 and/or uploaded into my ARIES record.

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

For Enrollment Site Agency Use Only

______________________________ ______________________________
Administered By *Agency Name/OA-HIPP/PCIP Enrollment Site*

______________________________ ______________________________
Signature *Date*

This client is a **NON-SHARE** client because: __ Unable to give consent