CARDEA | OAA | ALAMEDA COUNTY PUBLIC HEALTH DEPARTMENT

CONSENT TO ENROLL IN EFHA PROGRAM AND CONSENT TO RELEASE OF INFORMATION

CASE MANAGEMENT POLICY:

Provide guidance on the *"Consent to Enroll in Ryan White EFHA Program and Release of Information."*

POLICY:

No client information is to be released without a **signed and dated** Consent to Enroll and Release of Information form. All client records are confidential and are kept in a secure place.

PROCEDURE:

Confidentiality ensures that information regarding a client's HIV status (positive or negative), behavioral risk factors, or use of services cannot be released without his/her documented consent. Policies and procedures have been established that are in compliance with the Office of AIDS privacy protocol. Member agencies will take the necessary steps to ensure that their practice conforms to these policies and procedures.

For the purposes of planning and funding, the Alameda County Public Health Department, Office of AIDS Administration and Cardea Services must also ensure that reporting requirements are met that accurately depict client-level service utilization while protecting client identity and ensuring the highest possible standard of security. All clients must sign a *Consent to Enroll in the EFHA Program and Release of Information.* By signing this form, it allows for the entry of client identifying information into ARIES or other approved databases. No identifying information can be collected without the client's signature on this form.

CONSENT TO ENROLL IN EFHA PRORGRAM AND RELEASE OF INFORMATON:

I, ____ ***(Print Client's First, Middle Initial and Last Names),***
give my *'Consent to Enroll in the EFHA Program and Release of Information to Cardea Services'*.

I understand that my participation in RW EFHA Program is dependent upon my completion of this consent form, consenting to the release of my medical and identifying information into the database. I also agree to notify my case manager of any significant changes in my status (physical, mental, social, economic, residential or other) or of any intent I may have to change my enrollment in the EFHA Program. I also agree the information I provide to my Medical Case Manager is both accurate and true.

____	____________________	____________________
Signature of Client or Client's Legal Representative	**Date of Birth (DOB)**	**ARIES ID #**

____	____
Relationship (if signed by person other than Client)	**Date**

I can terminate this consent by submitting a written request to any of the agencies implementing Ryan White services, indicating that I no longer desire to receive services through the RW EFHA Program, or my written revocation of this authorization, whichever occurs first. I understand that I may refuse to sign this consent and that may result in being denied services, if eligibility for services is based on the verification of my diagnosis and the release of that information. I understand that I have the right to receive a copy of this consent.

This consent is valid for a period of three years from the date of the actual client signature above.
Provider agrees to not use or disclose personal health information beyond the scope of this authorization.