HIV Care Connect (HCC) Client Consent to Collection of and Authorization to Disclose Personal and Medical Information

The Office of AIDS (OA) is a division within the California Department of Public Health, Center for Infectious Diseases, responsible for coordinating California's programs, services, and activities related to HIV/AIDS. In that regard, OA maintains a data system, HIV Care Connect ("HCC"), a centralized HIV/AIDS client management system that allows for coordination of client services among medical care, treatment, and support providers and provides comprehensive data for program reporting and monitoring. When you participate in HCC, you will usually not need to re-register or provide proof of diagnosis multiple times when you receive services through various HIV care programs using HCC.

By signing this form, you are authorizing OA to receive information about you, services you are receiving, and services you may be eligible to receive under state- and federally-funded HIV care programs (such as the Ryan White HIV/AIDS Program (RWHAP), Housing Opportunities for Persons With AIDS Program (HOPWA), and the Medi-Cal Waiver Program (MCWP)) (altogether "HIV Programs") administered by state and federal agencies, local health jurisdictions, and community-based organizations. You also are also authorizing your provider to send information about you to OA regarding care and treatment you are receiving from an HIV Program.

The information you are authorizing OA to collect in HCC and consenting to OA sharing through HCC includes your name, date of birth, income, demographic data, HIV test results, diagnosis, medical information, benefits information, and information about services you receive, and to transfer the same data from other OA data systems, including the AIDS Drug Assistance Program Enrollment System, to HCC.

Only authorized personnel at an agency or service provider will have access to your information, and only on a need-to-know basis, as required under California law and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Information disclosed may be subject to re-disclosure and is no longer protected if it is disclosed to anyone other than a covered entity.

By signing this form, you are authorizing OA and the agencies and service providers that provide HIV Program services to you to use your information in HCC and you are consenting to their disclosure of information about you in HCC for the following purposes:

- To and from each other for coordination of care and benefits and for HIV Program monitoring and evaluation.
- To and from each other to comply with state and federal reporting requirements.
- To the California State Auditor, the California Data Insights and Innovations, the California Office of Information Security, or other state and federal agencies as required by law.

You agree that your consent and authorization in this form shall remain in effect for 3 years from the date of your signature below, and a digital or photocopy of this form shall be considered as valid as the original.

You have the right to modify or revoke this consent and authorization in writing by contacting CEMS@cdph.ca.gov. You also have the right to receive a copy of this form.

I hereby consent to and authorize the collection, use and disclosure of my personal information as set forth above.

Client/Representative* Name: _____

(Print)

Client/Representative Signature: _____ Date: _____

*If you are signing as a legal representative on behalf of the client, please provide documentation evidencing your appointment as the client's legal representation.