County of Los Angeles
Public Health

Division of HIV

Casewatch Millennium®
Client Consent Form

I, _____, *(print full name)* wish to register with Casewatch Millennium® in order to receive services funded by the Los Angeles County Department of Public Health (DPH), Division of HIV and STD Programs (DHSP). During registration, I will be asked to provide information about myself, including my name, race, gender, birth date, income and other demographic data.

By signing this form, I verify that I reside in Los Angeles County.

I understand that PrEP services may be available at multiple agencies, but my registration and service information will not be shared between agencies unless I choose to transfer my care to a different agency. I understand that my name and information will not be shared outside the Casewatch Millennium® system unless I provide my specific, informed consent for such a disclosure. A list of Casewatch Millennium® agencies that provide HIV biomedical prevention services is available upon request.

As a condition of receiving PrEP services, I agree that my information will be made available to my local health department and to fiscal agents that fund the services I receive. Additionally, this information will be made available to DPH/DHSP for mandated care and treatment reporting, program monitoring, statistical analysis and research activities. This information includes, but is not limited to, gender, ethnicity, birth date, zip code, HIV status, risk behavior information, referrals, 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 required by law.

By checking the "I AGREE and UNDERSTAND" box below, I understand that my relevant health, including HIV status, and income information will be shared with my local health department, fiscal agents that fund services I receive, and the Department of Public Health, Division of HIV and STD Programs. Only authorized personnel at each 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 required by law, such as threat of suicide or homicide. In most cases, I will not need to re-register (in Casewatch Millennium®) when I require services from an agency providing services funded by DPH/DHSP.

☐ **I AGREE AND UNDERSTAND**

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

By signing this form I acknowledge that I have been offered a copy of this consent form, and have discussed it with the staff person indicated below. I understand that this form will be stored in my paper file, and that this consent form remains in effect for three (3) years from the date I sign this form.

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_____ _____
Signature of Client or Parent/Guardian of Minor Child Date

For Local Health Care Agency Use Only

_____ _____
Administered By *Agency Name*

_____ _____
Signature *Date*

DHSP 12-001 (Rev 6/2012)