**CONSENT TO RELEASE OF INFORMATION**

**Consent to Release Information and Income Certification**

I,_____ certify that:
I authorize staff (including volunteer staff) of the following organizations, funded by Housing Opportunities for Persons With AIDS (HOPWA) and/or other sources ("Partners"), to release/share information regarding services I have received or requested, my HIV status, or my physical, financial, and/or mental condition among the same organizations for the express purpose of receiving or gaining access to services related to my current and future needs.

**Partners:** The Actors Fund, AIDS Healthcare Foundation - AHF Downtown, AHF El Monte, AHF Hollywood, AHF Westside, AHF Lancaster, AHF Carl Bean House, AHF Valley, AHF Whittier, AHF Redondo Beach, AHF Long Beach, AIDS Project Los Angeles, Alliance for Our Healthy Community, Alliance for Housing and Healing, AltaMed Health Service Corp., Andrew Escajeda Clinic, Antelope Valley Hope Foundation, Asian Pacific AIDS Intervention Team (APAIT), Being Alive, Bienestar Human Services, Catalyst Foundation, CHIRP LA, City of Pasadena, City of West Hollywood, Covenant House, County of Los Angeles Public Health Division of HIV and STD Programs (DHSP), East Valley Community Health Center, El Proyeto del Barrio, Entertainment AIDS Alliance, Foothill AIDS Project, Harbor UCLA Medical Center, Hollywood Community Housing Corp., Hollywood Access Ctr, Housing Authority of the City of Long Beach, Housing Authority of the County of Los Angeles, Inner City Law, JWCH Institute, Inc., L.A. Family Housing, Los Angeles Housing & Community Investment Department, Los Angeles County Development Authority (LACDA), Los Angeles Homeless Services Authority (LAHSA), Los Angeles LGBT Center, Maternal Child Clinic, Memorial Miller Children's Hospital, Modern Health Inc., Minority AIDS Project, Northeast Valley Health Corp., Oasis Clinic, Olive View Medical CTr, OPCC, Pets are Wonderful Support-Los Angeles, Project Angel Food, Project New Hope, Prototypes/Women's Link, Rand Schrader 5P-21, Safe Refuge, Salvation Army Alegria House Salvation Army Bell Shelter, South Bay Family Health Care, Skid Row Housing Trust, Special Services for Groups, Spectrum Community Services & Research, SRO Housing, St. Mary's Medical Center CARE Program, Tarzana Treatment Center, The Center for HIV Law & Policy, T.H.E. Clinic, United Way– Emergency Food and Shelter Program, Valley Community Healthcare, Venice Family Clinic Common Ground, The People Concern (LAMP), Volunteers of America, Watts Health Center, Watts Labor Community Action Committee, Wingart Center, West Hollywood Community Housing Corp., Homeless Outreach Program Integrated Care System (HOPICS), Los Angeles Centers for Alcohol and Drug Abuse (LA CADA ), and Whittier Rio Hondo AIDS Project

Additionally, I hereby authorize the Partners to exchange pertinent information about me with the following organizations not listed above:

Other organization(s)/business(es): _____ Initials: _____ Date: _____

This authorization expires two years after the date of this signed consent from. I am aware that I have the right to revoke this consent at any time by submitting written notification to Alliance for Housing and Healing at 825 Colorado Blvd, Suite 100 Los Angeles, CA 90041. Your notice of revocation will not apply to actions taken by the above-listed organization(s) prior to the date your written notification is received.

I understand that I may refuse to provide consent, and my refusal will not affect my eligibility for benefits or my ability to obtain treatment or payment but this may require me to access services from another provider.

I acknowledge that any assistance given to me is based upon this certification and the truthfulness of the information provided. I hereby authorize the Partners to take any reasonable steps necessary to verify the truthfulness of the information contained herein and information submitted by me to obtain assistance.

I acknowledge and agree that as a recipient of HOPWA funded services if the total amount of my monthly income changes or my residency changes, I will provide Alliance for Housing and Healing with the appropriate documentation to verify this change.

_____ _____

Client Name (Head of Household) Signature Date (MM/DD/YYYY)

_____ *(Ct's Initials) Client Received Copy*