FORM A3

City of Miami
Housing Opportunities for Persons with AIDS (HOPWA)
MEDICAL VERIFICATION FORM
CONSENT FOR RELEASE & EXCHANGE OF INFORMATION

I, ____ , hereby agree to allow the City of Miami HOPWA Program and its contracted HOPWA Agencies to obtain information regarding my medical condition for the purpose of qualifying me for the Housing Opportunities for Persons with AIDS (HOPWA) Program. Such information may include HIV status, lab results, medical records and data regarding illnesses/opportunistic infections I have had. I understand that to be eligible for HOPWA assistance there must be medical evidence as defined by the Centers for Disease Control that I have AIDS.

Yo, ____ , por la presente permito a la Ciudad de Miami, programa HOPWA y a agencias que trabajan con este programa bajo contrato con la ciudad, a obtener información sobre mi condición médica para calificarme para poder participar en este programa. Esta información puede incluir mi estatus de HIV, resultados de laboratorio, records médicos e información relacionada a mis enfermedades o infecciones oportunistas que he tenido. Yo entiendo que para ser elegible para recibir asistencia del programa HOPWA tiene que existir evidencia médica según lo definido por los Centros para el Control y la Prevención de Enfermedades (CDC) que yo tengo SIDA.

____
Signature of Client *(Firma del Cliente)*

____
Date *(Fecha)*

____
Client's Social Security Number *(Número de Seguro Social del Cliente)*

> This form **MUST** be submitted along with a Housing Assistance Waitlist Application available from February 10th to 21st, 2020.
> *Este formulario **TIENE** que ser sometido junto a la Solicitud – Lista de Espera para Asistencia de Vivienda que estarán disponibles de 10 al 21 de Febrero, 2020.*

Dear Doctor:

The person named above is applying for assistance through our Housing Opportunities for Persons with AIDS (HOPWA) program. Please provide the information request below.

Does this client have AIDS?
☐ *YES* ☐ *NO*

Date of Initial AIDS Diagnosis: ____________________
(as defined by the CDC)

Is the client HIV+?
☐ *YES* ☐ *NO*

Date of most recent HIV Test: ____________________

The Florida Fraud Law states that a person who knowingly aids and abets another person in obtaining aid or benefits under a state or federally funded assistance program by failing to disclose a material fact used in making a determination as to such a person's qualifications to receive aid or benefits, is guilty of a punishable crime.

I hereby certify that the above-name individual is my patient and that he/she has tested HIV+ or has AIDS as defined by the Centers for Disease Control (CDC). This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of such information without the specific written consent of the person to whom such information pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

____
Physician's Name (Print)

____
Physician's Signature

____
Clinic/Hospital/Healthcare Agency

____
Medical FL License Number

____
Telephone Number

____
Fax Number