

AUTHORIZATION FOR DISCLOSURE OF THE RESULTS OF THE HIV ANTIBODY BLOOD TEST

Patient's Name: _____ MR#: _____

EXPLANATION: This authorization for use or disclosure of the results of a blood test to detect antibodies to the Human Immunodeficiency Virus (HIV), the probable causative agent of Acquired Immune Deficiency Syndrome (AIDS), is being requested of you to comply with the terms of the Confidentiality of Medical Information Act, Civil Code Section 56, et seq and Health and Safety Code Section 199.21 (G).

AUTHORIZATION: I hereby authorize _____
(Name of Physician, Hospital or Healthcare Professional)

to furnish to _____
(Name or Title of Person Who is to Receive Results)

the results of the blood test for antibodies to HIV.

USES: The requester may use the information for any purpose, subject only to the following limitations:

DURATION: This authorization shall become effective immediately and shall remain in effect indefinitely, or until _____, whichever is shorter.
(Date)

RESTRICTIONS: I understand that the requestor may not further use or disclose the medical information, unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

ADDITIONAL COPY: I further understand that I have a right to receive a copy of this authorization upon my request.

Copy requested and received: Yes No Initial _____

Date: _____ Time: _____ AM/PM

Signature of Patient

Signature of Parent/Conservator/Guardian

Signature of Witness

If signed by other than Patient, indicate relationship

MAY VARY STATE-TO-STATE

*This authorization may be signed by a person other than the patient only under the following circumstances:

1. The patient is under 12 years of age or, as a result of his/her physical condition, is incompetent to consent to the HIV antibody blood test or the release of the test results, and
2. The person authorizing the release of the test results is lawfully authorized to make healthcare decisions for the patient, i.e., an attorney-in-fact appointed under the Durable Power of Attorney for Healthcare, the parent or guardian of a minor, an appropriately authorized conservator, or under appropriate circumstances, the patient's closest relative or to practice preventative measures Health and Safety Code Section 199.27.