

AUTHORIZATION FOR DISCLOSURE OF HIV TEST RESULTS

I hereby authorize _____, MD, to release the HIV test results of _____ (patient) to _____

This authorization is limited to the following purpose: _____

This authorization is effective immediately and shall remain in effect until (date).

I understand that the requestor may not further use or disclose this medical information unless I authorize such further use or disclosure or unless such use or disclosure is specifically required or permitted by law.

Signed _____

Dated _____

If not signed by patient, please indicate relationship:

- parent or guardian of minor patient under 12 years old
- guardian or conservator of incompetent patient