SADDLEBACK MEDICAL GROUP

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

Patient Name: _____ Date of Birth: _____
Address: _____ State: _____ Zip: _____

A. 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

B. Authorization

I hereby authorize _____
(Facility Name and Physician Name)

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

the results of the blood test for antibodies to the HIV.

C. Uses

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

_____

_____

D. Duration

This authorization shall become effective immediately and shall remain in effect indefinitely, or until _____, whichever is shorter.

E. Restriction

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.

_____ _____
Dated ***(Patient, Parent, Guardian, or Authorized Representative of the patient)***

_____
(If signed by other than patient, indicate relationship)