Results of the HIV Antibody Blood Test

A. EXPLANATION

This authorization to use or disclose the results of a blood test to detect antibodies to the Human Immunodeficiency Virus (HIV), the likely cause of Acquired Immunodeficiency Syndrome (AIDS), is being requested of you. This request is to comply with the terms of the Confidentiality of Medical Information Act.

B. AUTHORIZATION

I hereby allow ____ to give to

Name of physician, hospital or health care provider

____ the results of the blood

Name or title of person who is to receive results

test for antibodies to the HIV virus.

C. USES

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

____.

D. DURATION

This authorization shall go into effect right away and stay in effect indefinitely or until

Date _________________________, 20____, whichever is shorter.

E. RESTRICTIONS

I understand that the requester may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically needed or allowed by law.

F. ADDITIONAL COPY

I further understand that I have a right to get a copy of this authorization upon my request.

Copy requested and received: ☐ Yes ☐ No _______________ Initial

Date ________________ 20 ________ ____
Signature

____
Printed Name