

Patient Consent for Disclosure of Information

I **authorize** the **release** of my protected health information to the following person(s):

NAME: _____

ADDRESS: _____

PHONE: _____

RELATION TO PATIENT: _____

Limitations on the information you may release subject to this Release Form are as follow: _____

<p>HIV/AIDS: I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS with the rest of my medical records.</p> <p>Initial: _____ Date: _____</p>
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[] **I DO NOT AUTHORIZE THE RELEASE OF MY INFORMATION TO ANYONE**

Patient Signature (or Parent, Guardian, or Legal Representative) Date

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) listed above