PLACE LABEL HERE

AUTHORIZATION TO DISCLOSE INFORMATION TO FAMILY MEMBERS AND OTHER PERSONS DIRECTLY INVOLVED IN MY HEALTH CARE

I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION (INCLUDING MY HIV / AIDS RELATED INFORMATION, IF ANY) TO THE FOLLOWING FAMILY MEMBER, LEGAL REPRESENTATIVE, CLOSE PERSONAL FRIEND, OR OTHER PERSONS WHO MAY BE INVOLVED WITH MY CARE OR PAYMENT OF HEALTH CARE SERVICES ON MY BEHALF.

REPRESENTATIVES NAME _____

RELATION _____ CONTACT # (_____) _____

REPRESENTATIVES NAME _____

RELATION _____ CONTACT # (_____) _____

REPRESENTATIVES NAME _____

RELATION _____ CONTACT # (_____) _____

I ALSO AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION (INCLUDING MY HIV / AIDS RELATED INFORMATION, IF ANY) TO ANY PERSON INDENTIFIED BY ME IN THE COURSE OF MY TREATMENT TO THE EXTENT SUCH INFORMATION IS DIRECTLY RELEVANT TO THIS PERSON'S INVOLVEMENT WITH MY CARE OR PAYMENT OF HEALTH CARE SERVICES ON MY BEHALF.

_____ _____

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE DATE

_____

PRINTED NAME OF PATIENT OR PERSONAL REPRESENTATIVE