Santa Clara Family Health Plan™

Authorization for Release of HIV/AIDS Test Results

Name of Patient	Date of Birth	Social Security #

1. *I hereby authorize* _____ (M.D., agency or institution responsible for the above patient's care) to furnish HIV/AIDS TEST RESULTS concerning the above named patient to:

_____
(Name & address of receiving person or institution)

2. *I authorize* the following persons or entities to have access to the above information:

_____
(Name or function of the persons or entities authorized to have access to the HIV/AIDS test results)

3. *I authorize* that the information may be used only the following purposes:

_____

_____

_____

4. *I understand* that written authorization is required for each separate disclosure of the test results, and that the receiving person/entity will not further release these records without my additional consent.

5. *I understand* that I have the right to receive a copy of this authorization. This authorization to release records is effective _____ (today's date), and will remain effective for sixty (60) days from this date.

Patient Signature: _____ **Date:** _____

Parent/Guardian/Conservator Signature: _____ **Date:** _____

Print Name: _____

Please indicate Relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

Patient's Treating Physician Signature: _____ **Date:** _____
(Required)

(Pursuant to Health and Safety Code 120980, Civil Code 56.17)