

RELEASE OF INFORMATION RELATING TO HIV ANTIBODY TESTING

I authorize _____
(doctor's name)

of _____

to release my identity and: [select and initial one]

_____ The fact that an HIV test was ordered; or

_____ Any and all HIV test results and information from my record;

to _____

for the purpose of: _____

Release must occur within the next _____ days / months. [cross one out]

MY SIGNATURE BELOW INDICATES THAT I UNDERSTAND AND AGREE TO THE FOLLOWING:

I UNDERSTAND THIS IS NOT A BLANKET AUTHORIZATION FOR RELEASE OF INFORMATION. IT IS INTENDED FOR ONE-TIME USE ONLY. I MUST RE-EXECUTE IT SHOULD ADDITIONAL REQUESTS FOR INFORMATION OCCUR. I UNDERSTAND THAT THIS AUTHORIZATION HAS BEEN PREPARED IN ACCORDANCE WITH ORS 433.045 AND OAR 333-012-0270. I ALSO UNDERSTAND THAT OREGON LAW ALLOWS HIV TEST INFORMATION TO BE ENTERED IN MY MEDICAL RECORD AND TO BE SEEN BY OR SHARED ORALLY WITH PERSONS WHO MUST REVIEW THE RECORD FOR THE PURPOSE OF DELIVERING HEALTH CARE TO ME OR FOR ROUTINE ADMINISTRATIVE PURPOSES. I FURTHER UNDERSTAND THAT OREGON LAW ALSO REQUIRES MY PHYSICIAN TO REPORT MY IDENTITY AND/OR HIV ANTIBODY TEST RESULTS TO PUBLIC HEALTH AUTHORITIES UNDER CERTAIN CIRCUMSTANCES WITHOUT MY AUTHORIZATION.

Name of patient _____

(signature of patient or, if patient is incapacitated, signature of patient's representative)

(if patient is incapacitated, relationship of representative to patient)

Date: _____

OMA-HIVRI-99