THIS IS ONLY A SAMPLE!!! PLEASE WRITE YOUR OWN BASED ON THE SPECIFIC NEEDS/SITUATION OF YOUR PRACTICE.

Sample – Consent to Disclose Confidential HIV – related Information

I, (PATIENT NAME), authorize (PHYSICIAN HOLDING RECORDS) or an authorized representative, to release photocopies of all medical records, charts, notes, x-rays, and any other information related to my general physical condition, including confidential HIV-related information. I authorize the release of this information to (PERSON or ORGANIZATION RECEIVING RECORDS) for the purpose of (REASON FOR RELEASE), and allow him/her/it, or any physicians appointed by him/her/it to examine this information.

I understand that this consent is subject to revocation at any time except to the extent that (PERSON RELEASING RECORDS), or the person/entity making the disclosure, has already acted upon it.

The consent will terminate (DATE OF TERMINATION), unless I earlier revoke my consent. A photocopy of this document may be used instead of the original.

SAMPLE

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Signature

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Date