Center for Prevention and Treatment of Infections
PERSONAL RELEASE OF HEALTHCARE INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: _____
(LAST, FIRST, MIDDLE INITIAL)

I would like the Center for Prevention and Treatment of Infections to have the ability to discuss my care with the following individuals:

Name: _____ Phone: _____
This person is aware of my HIV status: ___ YES ____ NO
My physician can discuss all health information with this person: ____YES ____NO
If no, what information CAN the physician discuss with this person:

_____
_____
_____
_____

Name:_____ Phone: _____
This person is aware of my HIV status: ___ YES ____ NO
My physician can discuss all health information with this person: ____YES ____NO
If no, what information CAN the physician discuss with this person:

_____
_____
_____
_____

Name: _____ Phone: _____
This person is aware of my HIV status: ___ YES ____ NO
My physician can discuss all health information with this person: ____YES ____NO
If no, what information CAN the physician discuss with this person:

_____
_____
_____
_____

If you would not like your care discussed with anyone, please initial here: _____

PATIENT SIGNATURE: _____ DATE: _____