



Authorization for Disclosure of Results of *HIV* Test

This authorization for the disclosure of the results of the blood test to detect antibodies to the Human Immunodeficiency Virus (HIV), the probable causative agent of *AIDS* (acquired immune deficiency syndrome), is being requested in harmony with confidentiality requirements of California Civil Code Section 56, *et seq.* and California Health and Safety Code Section 120980 (g).

PLEASE PRINT:

Patient Name (Last, First MI) _____ Birthdate _____ UCI Student ID No. _____
Address _____ City _____ State _____ Zip Code _____ Telephone Number _____

AUTHORIZATION: I hereby authorize UCI Student Health Center to furnish the results of the blood test for *HIV* to:

LIMITATIONS: The requester may use the information for any purpose, subject to the following limitations:

I understand that the requester may not further use or disclose this medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

I further understand that I have a right to receive a copy of this authorization, upon request.

Copy requested & received: Yes No

Signed: _____ Date: _____
(Signature of Patient or Legal Representative)

Legal Relationship (if signed by other than the patient): _____

For Dept. Use Only

Med Rec No.: _____

Mailed Faxed Hand Carried by Pt.

Date Completed: _____

Initials: _____