Alta Bates Summit Medical Center
A Sutter Health Affiliate

AUTHORIZATION FOR USE OR DISCLOSURE OF THE RESULTS OF THE HIV TEST

Explanation

This authorization for use or disclosure of the results of a test to detect the presence of the Human Immunodeficiency Virus (HIV), the probable causative agent of Acquired Immune **Deficiency Syndrome (AIDS),** is being requested of you to comply with the terms of the Confidentiality of Medical Information Act [Civil Code Section 56 et seq.] and Health and Safety Code Section 120980(g).

Authorization

❑ Alta Bates Summit Medical Center ❑ Other, specify _____
is authorized to furnish the results of my HIV test to (enter name, phone and address of recipient) _____
Name Phone

_____
Address Street City State Zip

The recipient may use my health information only for the following purposes: (not required when patient is the recipient) _____

Expiration

This authorization expires on _____
Date

Restrictions

California law prohibits the recipient from making further disclosure of your health information unless the recipient obtains another authorization from you or unless the disclosure is required or permitted by law. This protection does not extend to recipients outside the state of California.

Your Rights

- I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment or payment.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to this address: Alta Bates Summit Medical Center, Health Information Department, 2450 Ashby Avenue, Berkeley, CA 94705 or 350 Hawthorne Ave, Oakland, CA 94612.
- My revocation will be effective upon receipt, but will have no impact on uses or disclosures made while my authorization was valid.
- I have a right to receive a copy of this authorization. If this box ❑ is checked, a copy was requested and received. Initials _____
- I may inspect and obtain a copy of the health information that I am authorizing for use or disclosure.

Your Signature

Patient name (print name) _____ Date of birth _____

Patient legal representative signature* _____ Date _____

If other than patient, indicate relationship _____

Witness _____

*This authorization may be signed by a person other than the patient only under the following circumstances:

1 The patient is under twelve (12) years of age or, as a result of his/her physical or mental condition, is incompetent to consent to the HIV antibody blood test or the release of the test results; and

2. The person who authorizes the release of the test results is lawfully authorized to make health care decisions for the patient, e.g., an agent appointed in a power of attorney for health care; the parent or guardian of a minor; an appropriately authorized conservator, or, under appropriate circumstances, the patient's closest available relative (see chapters 2 and 22 of the CHA Consent Manual).

Authorized Agent:
Knox Attorney Service, Inc., Knox Services LLC.