VERIFICATION OF HIV STATUS

Informed Consent for Disclosure of Information

I, _____(print name) hereby authorize Dr. _____ to release, disclose, and provide the information requested to the Interior AIDS Association, or any employee designated by them. It is my intention by this authorization to comply with any applicable statutes requiring my full and informed consent for otherwise privileged information. A photocopy of this authorization shall be considered as valid as the original.

_____ _____

Client (or duly authorized representative) Date

_____

Witness

I certify and say that _____

(name of patient)

is HIV seropositive and/or has been diagnosed with AIDS. If I have made the determination that my patient has AIDS, I have based my conclusion on the standards set by the Centers for Disease Control (CDC).

My patient's HIV status is (circle one):

Seropositive (Asymptomatic)

Seropositive (Symptomatic)

AIDS

Undetermined

Based on the same standards set by the CDC, the opportunistic diseases I have observed in my patient are:

_____

_____

_____

_____

The HIV-related disabilities I have observed in my patient are:

_____

_____

_____

_____

_____ _____

Physician's Signature Date

This form or attached materials should be mailed first class and marked confidential.
IAA Client Services, P.O. Box 71248, Fairbanks, AK 99707-1248