AUTHORIZATION TO DISCLOSE INFORMATION TO FAMILY MEMBERS AND OTHER PERSONS DIRECTLY INVOLVED IN MY HEALTH CARE.

I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION (INCLUDING MY HIV / AIDS RELATED INFORMATION, IF ANY), TO THE FOLLOWING FAMILY MEMBER, LEGAL REPRESENTATIVE, CLOSE PERSONAL FRIEND(S), OR OTHER PERSONS WHO MAY BE INVOLVED WITH MY CARE OR PAYEMENT OF HEALTH CARE SERVICES ON MY BEHALF.

REPRESENTATIVE(S) NAME ____

RELATION ____

REPRESENTATIVE(S) NAME ____

RELATION ____

REPRESENTATIVE(S) NAME ____

RELATION ____

REPRESENTATIVE(S) NAME ____

RELATION ____

I ALSO AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION (INCLUDING MY HIV / AIDS RELATED INFORMATION, IF ANY) TO ANY PERSON IDENTIFIED BY ME IN THE COURSE OF MY TREATMENT TO THE EXTENT SUCH INFORMATION IS DIRECTLY RELEVANT TO THIS PERSON'S INVOLVEMENT WITH MY CARE OR PAYEMENT OF HEALTH CARE SERVICES ON MY BEHALF.

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SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE DATE

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PRINTED NAME OF PATIENT OR PERSONAL REPRESENTATIVE