

## 24/7 Illinois Perinatal HIV Hotline

### RELEASE OF INFORMATION

I, \_\_\_\_\_ (name of client) hereby authorize the following organizations and individuals to disclose information as described below to the 24/7 Illinois Perinatal HIV Hotline for the purpose of coordinating follow-up treatment and care: \_\_\_\_\_ (referring institution), Pediatric AIDS Chicago Prevention Initiative (PACPI), Northwestern Memorial Hospital, and \_\_\_\_\_ (place or places to which I am referred).

Information which may be shared with the 24/7 Illinois Perinatal HIV Hotline includes, but is not limited to, any information about my and my baby's HIV/AIDS status and treatment (if applicable), and my mental health and substance abuse status and treatment. The information may consist of \_\_\_\_\_, laboratory reports, clinic/office records, other medical and social work reports, and also include my contact information.

I also specifically authorize the 24/7 Illinois Perinatal HIV Hotline to disclose the information described above that the Hotline receives regarding my and my baby's HIV/AIDS status and treatment (if applicable), and my mental health and substance abuse status and treatment with the organizations and individuals listed above for the purpose of coordinating follow-up treatment and continuity of care.

I understand that I have the right to inspect and copy the information to be disclosed. This authorization is valid for one (1) year from the date I sign it. I may revoke it earlier, but I understand that revoking it will not undo any information which has already been shared. I understand that I do not have to consent to this disclosure in order to receive services from my health care providers.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_