Release of Information:

Preliminary Positive Rapid Test Results

I, [name of client]_______________________________ hereby authorize _________________________________[current health care provider] to disclose my preliminary HIV status and my contact information to PACPI (Pediatric AIDS Chicago Prevention Initiative) for case management follow-up, _______________________________________ [referral case management service], and _______________________________________ [health care provider / institution] for the purpose of following up with my health care and Confirmatory HIV Test Result.

I also authorize the case manager to discuss my case, including my HIV status, with my specialty care provider, _______________________.

I do/do not (circle one) also agree that the case manager and my health care provider may disclose and share information, if any, about any mental health diagnosis or treatment I may need.

I do/do not (circle one) also agree that the case manager and my health care provider may disclose and share information, if any, about any substance abuse diagnosis or treatment I may need.

This disclosure will be valid for one year from the date of my signature. I may revoke it at any time. I understand that I do not have to consent to this disclosure in order to receive services from my health care provider.

Signed ____ Date _________________

Witness _______________________________ Title/Position ___________________

If signed, fax to PACPI (312-334-0973) with the Preliminary Positive form