HIPAA-COMPLIANT AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION BLOOD/BODY FLUID EXPOSURE INCIDENT (STAFF)

Patient/Staff Name:_____Date of Birth:_____

I hereby authorize_____ [insert health care provider name, address and telephone] to release my health information/records for the purpose listed below to:

_____[insert name of school official]

_____[insert name of school/school district]

_____[insert school address and telephone/fax]

Description:
The information to be disclosed consists of:

Results of blood tests on the SOURCE person for the presence of HIV and HBV and HVC antibodies, performed after a blood/body fluid exposure incident on _____(date)

Purpose:
This information will be used for the following purpose(s):
This information will be shared only between the PHYSICIAN OF RECORD of the EXPOSED person involved in the blood/body fluid exposure incident listed above, and the PHYSICIAN OF RECORD listed in section one of this form. This information is required to facilitate treatment of the EXPOSED person. School official will only facilitate contact between physicians.

Authorization

This authorization is valid for one calendar year. It will expire on _____[insert date]. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I also understand that if I refuse to sign, such refusal will not interfere with my ability to obtain health care or affect my employment status.

_____

Staff Signature Date

Copies: Staff Member
Physician or other health care provider releasing the protected health information
School official requesting/receiving the protected health information

Original: March 5, 2008