1. This authorization for use or disclosure of the results of a blood test to detect the presence of antibodies to the human immunodeficiency virus (HIV), the hepatitis B virus (HBV), and the hepatitis C virus (HCV) is being requested of you to comply with the provisions of the Confidentiality of Medical Information Act, Civil Code section 56 et seq., and Health and Safety Code section 199.21(g).

2. I, ________________________________, hereby authorize

(name of healthcare provider) ________________________________

to furnish to:

___a. (designated representative) ________________________________

___b. (exposed/injured person) ________________________________

___c. both of the above

the results of the blood tests to detect the presence of HIV, HBV, and HCV antibodies.

3. The requestor may use the information for any purpose, subject only to the following limitations:

________________________________________________________________________

4. This authorization shall become effective immediately and shall remain in effect indefinitely or until (date) ____________________.

5. I understand that the person(s) identified above, receiving the information identified above, may not further use or disclose the medical information unless another authorization is obtained from me, or unless such use or disclosure is specifically required or permitted by law.

6. I understand that I am entitled to a copy of this authorization upon my request.

Date: __________ Signature: ________________________________

Printed name: ________________________________

Parent/guardian's signature if minor: ________________________________

Witness/translator______________________________

EXPOSED INDIVIDUAL SHOULD TAKE THIS FILLED-OUT FORM, ALONG WITH BLOOD SAMPLES DRAWN ON CAMPUS, TO DESIGNATED WORK-RELATED-INJURY PROVIDER IN THE EVENT THAT THE SOURCE PATIENT WILL NOT GO IN PERSON FOR BLOOD TESTS.