DEPARTMENT OF CHILDREN, YOUTH, AND FAMILIES

Disclosure of Confidential HIV / AIDS Information

Section I

I, _____, have received the following information concerning
CARE PROVIDER'S NAME

_____.
CHILD'S NAME

- ☐ HIV / AIDS diagnosis
- ☐ Names / telephone numbers of treatment providers (See Section II)
- ☐ HIV / AIDS exposure
- ☐ AIDS symptoms
- ☐ Activities / comments (See Section III)

Section II

PRIMARY MEDICAL PROVIDER	PUBLIC HEALTH / AIDS CASE MANAGER	OTHER
NAME	NAME	NAME
ADDRESS	ADDRESS	ADDRESS
TELEPHONE NUMBER	TELEPHONE NUMBER	TELEPHONE NUMBER

Section III: Activities / Comments

Section VI

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by state law. A general authorization for the release of medical or other information is not sufficient for this purpose.

I have read and understand the above statement.

CARE PROVIDER'S SIGNATURE	RELATIONSHIP TO CHILD
CARE PROVIDER'S SIGNATURE	DATE

Authority to disclose this information:
- ☐ RCW 70.24.105
- ☐ Court order
- ☐ Parent / guardian permission on file
- ☐ Child (14 or older) permission on file

CONFIDENTIAL: To be filed only in child's confidential HIV / AIDS files