VERIFICATION OF HIV STATUS

Informed Consent for Disclosure of Information

I hereby authorize _____ to release, disclose, and provide the information requested, to Interior AIDS Association, or any employee designated by them. It is my intention by this authorization to comply with any applicable statutes requiring my full and informed consent for otherwise privileged information. A photocopy of this authorization shall be considered as valid as the original.

Client: _____ Date: _____/_____/_____
(or duly authorized representative)

Witness: _____ Date: _____/_____/_____

I certify and say that _____ is HIV seropositive and/or has been diagnosed with AIDS, I have based my conclusion on the standards set by Center for Disease Control (CDC).

My patient's HIV status is (circle one):

Seropositive (Asymptomatic)	Seropositive (Symptomatic)
AIDS	Undetermined

Based on the same standards set by the CDC, the opportunistic diseases I have observed in my patient are:

_____
_____
_____
_____

The HIV-related disabilities I have observed in my patient are:

_____
_____
_____
_____

Physician's Signature: _____ Date: _____/_____/_____

This form or attached materials should be marked Confidential and hand delivered to Interior AIDS Association at 709 2nd Avenue, Fairbanks, AK 99701 or mailed first class to IAA, PO Box 71248, Fairbanks, AK 99707.