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| State_Seal3 | 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  AIDS symptoms  Names / telephone numbers of treatment providers  Activities / comments (See Section II) (See Section III)  HIV / AIDS exposure | | | | |
| **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** | | | | |
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| **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  Parent / guardian permission on file  Court order  Child (14 or older) permission on file | | | | |
| **CONFIDENTIAL: To be filed only in child’s confidential HIV / AIDS files** | | | | |