Iowa Department of Human Services

AUTHORIZATION TO RELEASE HIV-RELATED INFORMATION

This form must be used to release HIV-related information.

I give the Department of Human Services permission to release confidential HIV-related information regarding , , to the following:

- ☐ Foster care provider(s) where child is placed
- ☐ Health care professional providing care to the child
- ☐ Respite provider
- ☐ School personnel
- ☐ IFMC
- ☐ Other ______________________

HIV information shall be disclosed only to those persons who have a need to know in order to plan and to deliver services and treatment to the child named above.

This release automatically expires at the termination of services for the child.

I understand I have the right to request a list of the names of those individuals to whom disclosure has been made unless providing this information is prohibited by law or court order.

I understand that I may revoke this consent at any time by giving written notice to the Department of Human Services. I understand that any release made prior to my revocation that was based upon this authorization shall not constitute a breach of my rights of confidentiality.

Parent or Guardian	Date
Minor Child	Date
Witness	Date

Copy 1: Case File

Copy 2: Parent, Guardian or Child

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