AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION

COMPLETE THIS FORM ONLY IF YOU HAVE TESTED POSITIVE FOR HIV, HBV, OR HCV

PLEASE PRINT OR TYPE ALL INFORMATION AS REQUIRED

I authorize _____ and the physicians
Name of hospital/physician/facility

who treated _____ to release to
Name of patient

Louisiana State Board of Dentistry
P.O. Box 5256
Baton Rouge, Louisiana 70821-5256
225-219-7330

my medical record or specific information relative to:

TEST RESULTS FOR HUMAN IMMUNODEFICIENCY VIRUS, HEPATITIS B VIRUS OR HEPATITIS C VIRUS

I understand that the Louisiana State Board of Dentistry is mandated by R.S. 37:1747 to establish procedures for reporting a licensee's status as a carrier of HIV, HBV, or HCV, and that pursuant to Louisiana Administrative Code 46:XXXIII.1207, I am required by law to report my seropositive status or be subjected to those sanctions associated with violations of R.S. 37:776.

I further understand that the release of reports called for herein shall be maintained in confidence as required by Louisiana Administrative Code 46:XXXIII.1208.

_____ _____
Patient signature Patient's date of birth

_____ _____
Date of signature Patient's social security number

In patient _____ Emergency room _____
Date(s) Date

Outpatient _____
Date(s)/Type of service