HW Clinic

I, _____, hereby give consent to the following persons to discuss my records, and/or results including HIV, STD's and mental health, with Dr. A.R. Al-Khush and his staff as needed.

1. Name:_____ Relationship:_____

2. Name:_____ Relationship:_____

3. Name:_____ Relationship:_____

I,_____, do not give consent to release/discuss my medical records with any person.

I understand that I have the right to revoke this authorization, in writing, at any time and this may apply to one or more of the above persons.

_____ _____

Patient Printed Name Date

_____

Patient/Guardian Signature