California State University
Northridge

I,_____,(patient's or doctor's name), hereby consent to release the following information to the person who was exposed to this particular patient's blood/body fluid.

Patient's or Doctor's signature _____ on _____(date).

HIV antibody result dated_____

Hepatitis B surface antigen result dated_____

Hepatitis C antibody result dated_____

It will be conveyed by _____(Provider's name)

I acknowledge that this information will be treated with strict confidentially following HIPAA standards.

_____ _____
Student Signature Date

_____ _____
Printed Name Student ID#

_____ _____
Physician's Name Contact #