PENINSULA SCHOOL DISTRICT

Release of Information Regarding HIV/AIDS, Hepatitis B, Hepatitis C, or Other Sexually Transmitted Disease – EMPLOYEE

I,_____, have been diagnosed as having
(print name)

☐	Human Immunodeficiency Virus Infection (HIV)
☐	Acquired Immunodeficiency Syndrome (AIDS)
☐	Hepatitis B
☐	Hepatitis C
☐	Other Sexually Transmitted Disease (Describe):

I authorize disclosure of information about my diagnosis to:

Position	Print Name of Staff Member Receiving Information	Initials of Employee Releasing Information
Human Resources		
Supervisor		
Other:		
Other:		
Other:		

This release of confidential health information expires 90 days from the date signed.

"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 such records 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." (RCW 70.24.105 [5])

_____	_____	_____
Employee Signature	Employee Number	Date

This release will be stored in the employee's medical file in Human Resources.