ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

By my signature below, I acknowledge that I have the right to request and receive a copy of the Yale School of Medicine Notice of Privacy Practices.

Signature of Patient or Personal Representative	Date
Name (Print)	Relationship to Patient

PERMISSION TO OBTAIN HIV INFORMATION AND PROTECTED HEALTH INFORMATION FOR TREATMENT PURPOSES

I understand that the clinicians and staff of Yale School of Medicine ("YSM") might require confidential health information from my other treatment providers, for treatment purposes. Such information might include, for example, progress notes, operative reports, laboratory or imaging results, or results of other diagnostic tests.

By my signature below, I authorize YSM physicians and staff to obtain any and all health information that they require, for purposes of treatment, diagnosis or referral. I understand that this health information might include HIV-related information (including information about testing) and/or information relating to mental health treatment, or treatment for substance abuse, in accordance with Connecticut General Statutes §19a-581 and Chapter 899, and 42 C.F.R. Part 2, respectively.

Signature of Patient or Personal Representative	Date
Name (Print)	Relationship to Patient