VALLEY FORGE FAMILY PRACTICE
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Consent to Disclose Confidential HIV-Related Information

I, _____, authorize Dr. Lucy Hornstein, or an authorized representative, to release photocopies of all medical records, charts, notes and any other information relating to my general physical condition, including confidential HIV-related information to

_____

for the purpose of

_____and allow him/her or any physicians appointed by him/her to examine this information.

I understand that this consent is subject to revocation at any time except to the extent that Dr. Hornstein or the person/entity making the disclosure has already acted in reliance on it.

This consent will terminate _____, unless I revoke it earlier. A photocopy of this instrument may be used instead of the original.

_____
SIGNATURE

_____
DATE