PERSONS WITH HIV-RELATED ILLNESS EXHIBIT

The University of the State
of New York Education Department

Approved by:
New York State Department of Health

Authorization for Release of Confidential HIV-Related Information to the Superintendent of Schools and the Board of Education

OC-1 (6/89)

Confidential HIV Related Information means any information indicating that a person had an HIV related test, or has HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV.

Under New York State Law, except for certain people, confidential HIV related information can only be given to persons you allow to have it by signing this form. You may ask for a list of people who can be given confidential HIV related information even without this form.

If you sign this form, HIV related information can be given to the people listed on the form, and for the reason(s) listed on the form. You do not have to sign the form, and you can change your mind at any time.

If you experience discrimination because of the release of HIV related information, you may contact the New York State Division of Human Rights at (212) 870-9624 or the New York City Commission of Human Rights at (212) 566-5493. These agencies are responsible for protecting your rights.

NAME OF PERSON WHOSE HIV RELATED INFORMATION WILL BE RELEASED			
NAME AND ADDRESS OF PERSON SIGNING THIS FORM (IF OTHER THAN ABOVE)			
STREET	CITY	STATE	ZIP CODE
RELATIONSHIP TO PERSON WHOSE HIV INFORMATION WILL BE RELEASED			

NAME OF SCHOOL DISTRICT

Name and addresses of the Superintendent of Schools and individual members of the Board of Education (Board of Trustees) of the above named school district who will be given HIV related information.

SUPERINTENDENT'S NAME			
STREET	CITY	STATE	ZIP CODE
NAME			
STREET	CITY	STATE	ZIP CODE

*Human Immunodeficiency Virus that causes AIDS

(Continued on Reverse)

0150-E

NAME			
STREET	CITY	STATE	ZIP CODE
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STREET	CITY	STATE	ZIP CODE
NAME			
STREET	CITY	STATE	ZIP CODE

Reason for release of HIV related information

____ To approve the recommendation of the ___ CSE as required by law.
(*Name of district*)

____Other (explain in full, use additional sheet(s) if necessary

Time during which release is authorized FROM: TO:

_____ _____
Month Day Year *Month Day Year*

My questions about this form have been answered. I know that I do not have to allow release of HIV related information, and that I can change my mind at any time.

_____
Signature Date

Approved: July 1, 2001

Adopted November 5, 2001