St. Clair County Community Mental Health

Consent for Hepatitis B/HIV Blood Testing
Medical Release of Information

(This form is for SUD Use Only)

INDIVIDUAL NAME:_____ CASE #:_____

HOME/PROGRAM NAME:_____

I authorize HIV and/or Hepatitis B blood testing be performed in the event an agency employee or other individual sustains a percutaneous (through the skin), mucous membrane or open wound exposure to _____'s blood or other body fluids.
Individual Name

I further authorize the release of medical information concerning _____
Individual Name
including information regarding Hepatitis B (Hep B), Acquired Immune Deficiency Syndromes (AIDS), AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV), if applicable to St. Clair County Community Mental Health/designee and the Michigan Department of Consumer & Industry Services, Bureau of Regulatory Services, for the purpose of providing appropriate care to _____, or
Individual Name
the individual exposed to the body fluids. I understand that this authorization is required in order to comply with the licensing rules of the Department of Consumer & Industry Services, Bureau of Regulatory Services, for the purpose of providing appropriate care to_____, or the individual
Individual Name
exposed to the body fluids. I understand that this authorization is required in order to comply with the licensing rules of the Department of Consumer & Industry Services and OSHA rules.

_____
Signature of Individual/Guardian

_____
Date