

DOCTOR REFERRAL FORM

I, _____ HEREBY AUTHORIZE AIDS CARE PROJECT TO CONTACT MY PHYSICIAN FOR THE PURPOSE OF REQUESTING A LETTER CONFIRMING MY HIV STATUS AND REFERRING ME FOR ACUPUNCTURE SERVICES. ADDITIONALLY, PERMISSION IS GRANTED TO AIDS CARE PROJECT TO MAINTAIN AN ON-GOING DIALOGUE WITH MY PRIMARY CARE PHYSICIAN.

MY DATE OF BIRTH IS _____ (FOR IDENTIFICATION PURPOSES)

I RECEIVE MY MEDICAL CARE AT _____

MY PHYSICIAN'S NAME IS _____

MY PHYSICIAN'S PHONE NUMBER IS _____ FAX NUMBER _____

I UNDERSTAND THAT PURSUANT TO THE LAWS OF MASSACHUSETTS, THE PROVIDER CANNOT RELEASE THIS INFORMATION TO ACP WITHOUT MY WRITTEN INFORMED CONSENT, I UNDERSTAND THAT I AM NOT OBLIGATED TO GIVE SUCH CONSENT.

I HEREBY CONSENT TO THE RELEASE OF THE INFORMATION DESCRIBED ABOVE TO AIDS CARE PROJECT.

CLIENT'S SIGNATURE

DATE

CLIENT TELEPHONE

FOR M.D. USE ONLY

I, _____, REFER _____

FOR ACUPUNCTURE AT THE AIDS CARE PROJECT FOR HIS/HER HIV INFECTION.

M.D. SIGNATURE

DATE

HOSPITAL AFFILIATION

TELEPHONE NUMBER