Medical Verification Form

I, (Patient Name) _____, do hereby authorize AID Atlanta, Inc. or a representative thereof to obtain and release medical verification of my medical status from and to:

(Print clearly below)

Medical Provider Name: _____

Name of Clinic/Practice (if applicable): _____

Address: _____

I understand that this information will be shared between AID Atlanta and the above party for the purpose of coordinating care and services on my behalf.

Patient Signature: _____ **Date:** _____/_____/_____

Patient Date of Birth: _____/_____/_____ **Last 4 Digits of Patient SS#:** _____

CM Signature: _____ **Date:** _____/_____/_____

_____	_____	_____
Case Manager Name	**Phone #**	**Fax #**

Please confirm below		
I confirm this patient is HIV Positive	❑ Yes ❑ No	AIDS Dx? ❑ Yes ❑ No
Last TB Screen	Date: _____	Result: _____
Patient's last medical visit	Date: _____	
Patient's most recent CD4 count	CD4 Value: _____	Date: _____
Patient's most recent Viral Load count	VL Value: _____	Date: _____

_____	_____	_____
Signature (Doctor/Nurse/Clinic Stamp)	**License #**	**Date**

Revised 02/6/18