JUVENILE MATTERS
VICTIM'S DESIGNATION OF RECEIVER FOR CHILD'S HIV/AIDS TEST RESULTS
JD-JM-187 New 10-10
C.G.S. §§ 54-102a, 54-102b, 54-102C P.A. 10-43 § 41-42

STATE OF CONNECTICUT
SUPERIOR COURT
www jud.ct.gov

Instructions To Victim:
Send completed original and 1 copy to the clerk of court. Keep a copy for your records.

Instructions To Clerk:
Retain original in the court file.

To: The Superior Court for Juvenile Matters

Address of court	Docket number

Name of child	Name of victim

Designation of Health Care Provider/HIV Counseling and Testing Site

I designate *("X" one)*

☐ the health care provider named below to receive the results of the court ordered HIV/AIDS test performed on the child and to disclose the child's test results to me. ***I understand that the health care provider may charge me (or my insurance company) for any costs associated with disclosing the child's test results to me and that I am financially responsible for these costs. I also understand that I may be eligible for victim compensation for these costs and that I can contact the Office of Victim Services at (888) 286-7347 for additional information about victim compensation.***

Name, address and telephone number of health care provider

☐ the HIV Counseling and Testing Site, funded by the State of Connecticut Department of Public Health, named below to receive the results of the court ordered HIV/AIDS test performed on the child and to disclose the test results to me. ***I understand that the services provided by the HIV counseling and testing site are free of charge and that no costs for any services provided will be billed to me.***

Name, address and telephone number of HIV counseling and testing site

Consent to Release Name and Address to Provider/HIV Counseling and Testing Site

Great care is taken by the court to protect all juvenile matters case information from disclosure. If you give the Court permission to give your name and address to a health care provider or HIV counseling and testing site it is important for you to know that this information may no longer be protected as confidential. Although the Court cannot protect your information after it is disclosed to a health care or HIV counseling and testing site, there are several state and federal laws that protect the privacy of all information contained in a juvenile matters case and HIV/AIDS test information and medical information that may prevent further disclosure of your name and address by the health care provider or HIV counseling and testing site you have designated to receive this information.

I, *(enter name of victim)* _____ authorize the Superior Court for Juvenile Matters to disclose my name and address, in writing, to the health care provider or HIV counseling and testing site designated above. The purpose of this disclosure is to provide the above named health care provider or HIV counseling and testing site with the information for the health care provider or HIV counseling and testing site to contact me to tell the results of the child's court ordered HIV/AIDS test to me.

I understand that I have the right to change my mind and withdraw this authorization to release my information by completing and filing with the clerk of court the Withdrawal of Consent to Release Information provided below. I also understand that any such withdrawal of authorization will not apply to information that the Court has already given to the health care provider or HIV counseling and testing site I listed above in accordance with this release.

I have read and understand the above	Signed *(Victim)*	Date	Signed *(Parent/Guardian if minor)*	Date

Withdrawal of Consent to Release Information

I *(enter name of victim)* _____ withdraw my permission for the Superior Court for Juvenile Matters to disclose my name and address to the health care provider or HIV counseling and testing site I designated on *(date)* _____ .

I understand that by *(1)* signing this form the Court will not release my name and address to the health care provider or HIV counseling and testing site that I designated to receive the results of the Court ordered HIV/AIDS test of the child, and *(2)* the results will not be provided to me by the Court's designee. I also understand that if the Court released the information to the designated health care provider or HIV counseling and testing site before the Court received this withdrawal then this withdrawal is not valid.

I have read and understand the above	Signed *(Victim)*	Date	Signed *(Parent/Guardian if minor)*	Date