

**PATIENT CONSENT FOR HIV ANTIBODY BLOOD TEST**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby give permission to test my blood for the presence of the ANTIBODY to the Human Immunodeficiency Virus (HIV) that is associated with Acquired Immune Deficiency Syndrome (AIDS). I understand that withdrawing blood and using a substance to test the blood performs the test.

I have been informed that the accuracy and reliability are still uncertain and that the test results may, in some cases, indicate that a person has antibodies to the virus when the person does not (False Positive). The test may fail to detect that a person has antibodies to the virus when the person has the virus (False Negative). I also have been informed that a positive blood test result does not mean that I have AIDS, and that in order to diagnose AIDS other means must be used in conjunction with the blood test.

I have been informed that if I have any questions regarding the nature of the blood test, its expected benefits, its risks, and the alternative tests, I may ask those questions before I decide to consent to the blood test.

After the test results are obtained, my physician will discuss these matters with me and, if necessary, refer me for appropriate medical, psychological and social counseling.

I understand that the results of this blood test will only be released to those health care practitioners directly responsible for my care and treatment. However, if a health care worker involved in my care comes in contact with my blood or body fluids, test results will be released to their physician for purposes of follow-up and treatment only. No additional release of the results will be made without my written authorization.

I further understand that the results of this test will be recorded in my medical record and that the results will be released to persons and entities to which I specifically authorize the release of this record.

I specifically agree to release test results to applicable third party payers in order to obtain reimbursement for my medical expenses.

I have been given the opportunity to ask questions which have been answered to my satisfaction. I acknowledge that I have received the information I desire concerning the blood tests and the release of the results.

My signature below indicates that I give my informed consent to have the HIV blood test to detect antibodies to the HIV virus.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_