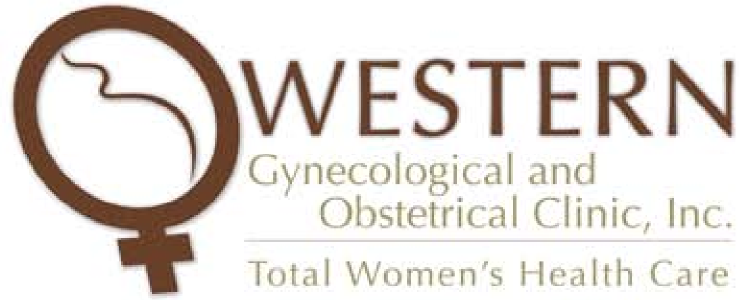
Consent for HIV/AIDS Testing



Name: ______________________________

Date of Birth: ______________________________

I have been informed that my blood will be tested for evidence of exposure or infection to/with the human immunodeficiency syndrome (AIDS). I understand that a blood sample is obtained to perform this test. I have also been informed that a positive test does not mean that I have AIDS and that in order to diagnose AIDS; other follow-up tests must be performed 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 alternative tests, I may ask those questions before I decide to consent to the blood test.

I understand that the results of this blood test will be maintained in my medical record and will be released to those health care practitioners directly responsible for my care and treatment This information is available to my health care provider for purposes of treatment, peer review and quality assurance purposes. I acknowledge that this information may be required to be released to the State Health Department pursuant to State law governing reporting of infectious diseases and/or occupational exposures of pre-hospital emergency personnel.

Further, I recognize that as a condition of treatment in this Clinic, I have given written permission for third party payors to have access to the information in my medical record I also realize that if I later authorize any additional release of my medical record to any other third party, I am granting them access to all the information in my medical record.

If you are pregnant or considering becoming pregnant:

The American College of Obstetricians and Gynecologists recommend that all pregnant women receive counseling and testing for the HIV virus.

The rate of transmission of HIV from pregnant women to their newborns is around 250/. However, treatment of women during pregnancy and delivery, coupled with treatment of the newborn following delivery can reduce the rate of transmission by approximately two-thirds.

By my signature below, I acknowledge that I have been given all of the information I desire concerning this test and release of the testing results and have had all my questions answered. Further, I acknowledge that I hereby give consent for the performance of this test to detect the human immunodeficiency virus.

ANONYMOUS TESTING IS AVAILABLE THROUGH THE HEALTH DEPARTMENT

______________________________	______________________________
Patient Signature	Date
______________________________	______________________________
Relationship if other than patient	Witness to signature

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