

University of
at

**CONSENT FOR HUMAN
IMMUNODEFICIENCY VIRUS (HIV)
ANTIBODY TESTING**

I understand that I may request that this test be performed either using my name or by some system by which I remain anonymous. I will so indicate my desire for anonymity or named testing verbally to the physician at the time of testing. I will be referred to an anonymous testing, if that is my desire.

I understand that if the test is performed with my name rather than anonymously, the information will be recorded in my medical record. All information regarding these test results is confidential; it will only be released pursuant to applicable State and Federal laws. Information will be released only upon the order of law or my permission. It must be noted that certain insurance programs request past medical history, and that if I give permission for release of my medical record the result of an HIV test not done anonymously will be released also. I understand that if my test should be positive, I will receive information regarding treatment and counseling options, and I may seek further evaluation at the University of Illinois or from another physician or hospital of my choosing.

I, _____, hereby give permission to the University of _____ at _____ to test my blood for the presence of antibody to the human immunodeficiency virus (HIV). Currently understood medical information indicates the virus to be the cause of the acquired immunodeficiency syndrome (AIDS).

I understand that the test itself is not diagnostic of AIDS and that the meaning of a positive test is still not entirely clear. I understand that a positive result from this test indicates the presence of antibodies to HIV in my blood. A positive result does not conclusively indicate that the virus is present nor does a positive result mean that I have AIDS. It simply means that I have been infected with HIV. There is no way at this time to predict from a positive test whether or not I will develop AIDS in the future. Furthermore, I understand that a negative test result does not conclusively exclude the possibility of being infected with HIV.

The test is known as an ELISA. Any positive ELISA test will be repeated and then a confirmation test approved by the United States Food and Drug Administration or Illinois Department of Public Health will be utilized.

I understand that there is considerable misinformation and social anxiety concerning the presence of the HIV or the disease AIDS. I understand that reliable medical and scientific information about the true methods of transmission have been sometimes overpowered by irrational fears. HIV is spread primarily by intimate sexual contact, blood to blood transmission or maternal to fetal or newborn transmission.

I understand that this test is voluntary and acknowledge that there was no force, duress, or other form of coercion involved in deciding to have this test performed. In addition, I recognize that my consent to this test may be withdrawn at any time.

I have had the opportunity to ask questions concerning this test as well as the HIV and they have been answered to my satisfaction. Understanding the above information, I consent to the performance of the HIV antibody test on my blood.

Signature of Patient or Patient's Legally Authorized Representative

Date

Signature of Physician-Witness

Policy Subcommittee of the UIH AIDS Advisory Committee

