UNIVERSITY MEDICAL CENTER

CONSENT FOR HIV BLOOD TESTING*

Patient's Name (print) _____

I understand that my physician has requested that a test(s) for HIV be performed on a sample of my blood. I understand that the test is a voluntary one. HIV is an abbreviation for Human Immunodeficiency Virus, the name of the virus now thought to be the cause of AIDS. The HIV test which will be performed is designed to detect the presence of the virus and/or antibody to the virus in the blood. The test is performed by withdrawing a sample of blood from a vein and submitting the specimen for evaluation.

Before I agree to have the blood test performed I should be aware of the following:

1. There is a small chance that the test results may in some cases indicate that a person has a positive test for the virus when the person does not (false positive) or fail to detect that a person has a positive test for the virus (false negative). If the first test is positive, it will be confirmed by a second test. A positive test does not necessarily mean that I will develop AIDS, and a negative test does not necessarily mean that I was not recently infected with the HIV virus (see accompanying sheet). Precautions will be taken to minimize the possibility of a false-reactive test.

2. The results of the test will be recorded in my medical record and any person involved in my health care will have access to that information. The performance and results of the HIV test(s) are considered confidential and the test results in my medical record shall not be released without my written permission, except to the individuals and organizations that have been given access by law who also are required to keep my medical record information confidential.

3. My signature confirms that I have read this consent form, have had the opportunity to ask any questions I had about the reason for the testing, the nature of the test and hereby agree to be tested for HIV.

WITNESS _____

PATIENT SIGNATURE _____

SIGNATURE OF OTHER RESPONSIBLE PERSON** _____

DATE OF SIGNATURE _____

RELATIONSHIP TO PATIENT _____

PHYSICIAN'S SIGNATURE _____

*Laboratory copy must be attached to laboratory requisition slip.

**If patient is a minor, parent or guardian must sign the consent above.

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