women's center for health

WRITTEN CONSENT FOR HIV ANTIBODY TESTING

please PRINT all information clearly

Patient's Name ______________________ Physician ______________________

I am giving my permission for a blood test to decide whether I have antibodies to HIV (human immunodeficiency virus) or any other identified causative agent of AIDS in my blood. I understand that the test results will be utilized for the purposes of my medical care and treatment.

I understand that the test is performed by withdrawing a sample of my blood and conducting laboratory tests to determine the presence of antibodies to HIV. I understand that the results of the blood tests considered to be positive will be reported to the Illinois Department of Public Health.

I further understand that a positive result does that not mean I have AIDS, but that my blood has been exposed to the AIDS virus, and that antibodies to that virus are present in my blood. I understand that counseling concerning AIDS will be offered to me if my test results are found to be positive.

I have been informed and understand that test results, in a percentage of cases, may indicate that a person has antibodies to the virus when the person does not have the antibodies (a false positive result), or that the test may fail to detect that a person has antibodies to the virus when the person does, in fact, have these antibodies (a false negative result).

I understand that my test results will be released to my physicians and other healthcare providers providing my care. In addition, I understand that the law allows my identity and test results to be disclosed to specific persons, such as the physicians and healthcare providers involved in the use of any donated organs or tissues, and the Illinois Department of Public Health, healthcare facility staff committees, and research studies (without name). I understand that my test results will be kept confidential to the extent provided by law. In addition, I understand that I may withdraw from the testing at any point in time, prior to the completion of laboratory tests.

My physician has advised me about the purposed, potential uses, limitations, and meaning of the test results; the voluntary nature of the test; the right to withdraw at any time prior to the completion of the laboratory test; and the confidentiality protection under the law. I understand that the fact that the test was performed and the results may be released to my insurance carrier. With the information presented above having been completely and clearly explained to me, and all of my questions having been answered, I hereby authorize (physician and/or hospital healthcare facility) to test my blood for HIV infection.

Signature of notation of test subject, or legally authorized representative ______________________

Signature of witness ______________________ Date ______________________