# CONSENT TO TESTING FOR HIV (AIDS)

I have been informed by my physician that my blood will be tested for the presence of antibodies to the Human Deficiency Virus (HIV), which is the virus that causes AIDS (Acquired Immune Deficiency). The presence of antibodies means that a person probably has been infected with the AIDS virus, but does not necessarily mean that a person will develop the disease.

Some individuals take up to three years to produce antibodies to the AIDS virus. During this time, they may test negative and still be infectious. Individuals who have good reason to believe that they have been exposed to the virus may wish to be retested at a later date (3 months) if their results are negative.

The fact that this test was offered to you does not mean that your doctor suspects you have been exposed to AIDS or are a member of a high risk group. In many people, the only sign of an AIDS virus infection may be positive blood test result. Other symptoms may not show until years after the exposure. This blood test is recommended because it may give important information needed for your care and the safety and/or care of others.

I understand that the test will be performed at a reference laboratory that will report the results only to my doctor. Results will be kept confidential.

I acknowledge that information regarding measures for the prevention of exposure to, and transmission of, Human Immune Deficiency Virus (HIV), is available to me upon request.

By my signature below, I acknowledge that I have been given all the information I desire concerning the blood test, release of results and have had all my questions answered. Further, by my signature, I acknowledge that I have given consent for the performance of a blood test to detect antibodies of the HIV virus.

Date: _____ 20___

Time: _____ a.m./p.m.

_____
Signature (Patient or Legal Guardian

_____
Patient's name (Printed)

_____
Witness