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HIV CONSENT FORM

I, hereby give permission to Dr. G. Q. Khan, his employees, associates and such assistants or laboratories as may be selected or designated by them to perform a blood test for the detection of antibodies to the human immunodeficiency virus (HIV) in my blood. This virus can cause the Acquired Immune Deficiency Syndrome (AIDS).

I have been informed that this test is reliable, but that a negative test does not conclusively exclude the possibility of infection with the virus. I have also been informed that a positive test usually means that I have been exposed to the virus but does not necessarily mean that I have AIDS or will necessarily develop AIDS in the future.

I understand that the test results will be recorded in my permanent medical record and will only be released to those healthcare practitioners directly responsible for my care and treatment. I understand that, as required by Florida State law, a positive test result must be reported to the Department of Health. I understand that no additional release of the results will be made without my written authorization. Furthermore, I understand that whenever I waive the privilege of confidentiality and privacy of my medical records or authorize the inspection or copying of my medical records, it will result in disclosure of the results.

I have been informed that release of the fact that the test was performed or of test results, particularly a positive result, may have an undesirable personal discrimination against me.

I have been advised about the purpose, potential uses, limitations and meaning of the test results; the voluntary nature of the test and the confidentiality protection under the law.

I have read the above and have had the opportunity to discuss this information with my physician (or his designee). I have been given the opportunity to ask questions which have been answered to my satisfaction. My signature below indicates that I have given my informed consent to have the HIV test performed on my blood.

Patient's Printed Name: _____

Patient's Signature: _____ Date: _____

Parent's Printed Name (If patient is a minor): _____ Relationship to Patient: _____

Parent Signature (If patient is a minor): _____ Date: _____