HIV Test Informed Consent

I consent to a human immunodeficiency (HIV) test, which is to determine if an individual is infected with the virus, which causes AIDS. I understand:

1. The blood test for HIV is not 100% accurate and sometimes produces false positive or false negative results.

2. More than one blood test may be necessary to confirm positive results.

3. That information identifying me and test results will be confidential and only those required or permitted by lay will know the results and my identity.

4. That my HIV test results can be released to those whom I give written permission to see or to copy my medical record.

5. I will be provided the test results and the opportunity to receive post-test counseling from my physician.

I acknowledge that I have received information regarding measures for the prevention of, exposure of, and transmission of HIV.

_____ _____

Date **Time** **Signature, Patient/Legal authorized Person**

_____ _____

Date **Time** **Witness**

PHYSICIAN ACKNOWLEDGEMENT

I have provided pre-test counseling, including measures for the prevention of, exposure to, and transmission of HIV, and the right to confidential treatment of the test results and the patient's identity as provided by law. After I explain the rest results, I will give the patient the opportunity to receive post-test counseling.

_____ _____

Date **Time** **Physician Signature**