HIV TESTING CONSENT FORM

PATIENT NAME: **DATE OF BIRTH:**

I consent to a human immunodeficiency (HIV) test which is used 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 a positive test result.
3. That information identifying me and test results will be confidential, and only those required or permitted by law 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 received post-test counseling from my physician.

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

Signature Patient/ Legally authorized person	Printed Name	Date
Signature Witness	Printed Name	Date

Physician Acknowledgement

I have provided pre-testing 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 the law. After I explain the test results to the patient, I will provide the opportunity for post-test counseling.

Signature Physician	Printed Name	Date

HIV TESTING WITHOUT AN INFORMED CONSENT

I certify that an HIV test is necessary for: *(Check Appropriate Box)*

- ☐ Medical diagnostic purposes to provide appropriate emergency care or treatment in a bona fide emergency and the patient is unable to consent.

  Or

- ☐ Medical diagnosis of an acute illness and obtaining informed consent would be detrimental to the patient.

  Or

- ☐ Providing appropriate care and treatment of a hospitalized infant and a parent/court appointed guardian cannot be contacted to provide consent.

Signature Physician	Printed Name	Date