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Health Department/Center

CONSENT TO TEST FOR ANTIBODIES TO THE HUMAN IMMUNODEFICIENCY VIRUS (HIV)

Information:

It is important for you to have a blood test to detect the presence of antibodies to the virus that causes the disease AIDS known as the Human Immunodeficiency Virus (HIV).

This procedure is performed as any routine blood test, by withdrawing a small amount of blood from the vein by needle.

This testing is important to insure that adequate precautions can be taken to prevent transmission of the virus to others should the results be positive and to help prevent future infections from the virus if the test is negative.

This testing is also important for your health care, if the test results are positive, so that the best available treatment may be provided as early in the stages of the disease as possible. Periodic follow-up tests will be performed as determined appropriate by the physician.

You will be informed of the results of the test and receive counseling and/or education concerning the AIDS virus. The results of the test will not be disclosed to anyone except persons authorized by law to receive such information. Such persons are required by law to keep the information confidential. All positive test results will be disclosed to the Department of Health. Other persons to whom the results may be disclosed include health care providers involved in your care or treatment, emergency medical services personnel, others who have access to the record for quality assurance, your parent(s) if you are a minor, or your spouse.

Consent:

I have received information about AIDS and AIDS (HIV) testing. I understand that the testing is recommended and that the results will remain confidential and will be provided to health care providers and others only as necessary. I further understand that this consent may be revoked in writing prior to the drawing of blood for further tests.

_____ I consent to performance of the AIDS (HIV) antibody test and such periodic tests as the physician determines appropriate.

_____ I do not consent to performance of the AIDS (HIV) antibody test.

SIGNED:_____ DATE:_____

WITNESS:_____ DATE:_____

(HIV2 REV 11/92)

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Health Department/Center

CONSENT TO ORAL TEST FOR ANTIBODIES TO THE HUMAN IMMUNODEFICIENCY VIRUS (HIV)

Information:

It is important for you to have an oral test to detect the presence of antibodies to the virus that causes the disease AIDS, known as the Human Immunodeficiency Virus (HIV).

This procedure is performed by placing a special pad with a handle between your cheek and gum for two minutes.

This testing is important to insure that adequate precautions can be taken to prevent transmission of the virus to others should the results be positive and to help prevent future infections from the virus if the test is negative.

This testing is also important for your health care, if the test results are positive, so that the best available treatment may be provided as early in the stages of the disease as possible. Periodic follow-up tests will be performed as determined appropriate by the physician.

You will be informed of the results of the test and receive counseling and/or education concerning the AIDS virus. The results of the test will not be disclosed to anyone except persons authorized by law to receive such information. Such persons are required by law to keep the information confidential. All positive test results will be disclosed to the Department of Health. Other persons to whom the results may be disclosed include health care providers involved in your care or treatment, emergency medical services personnel, others who have access to the record for quality assurance, your parent(s) if you are a minor, or your spouse.

Consent:

I have received information about AIDS and AIDS (HIV) testing. I understand that the testing is recommended and that the results will remain confidential and will be provided to health care providers and others only as necessary. I further understand that this consent may be revoked in writing prior to the collection of oral specimens for future tests.

_____ I consent to performance of the AIDS (HIV) antibody test and such periodic tests as the physician determines appropriate.

_____ I do not consent to performance of the AIDS (HIV) antibody test.

SIGNED:_____ DATE:_____
Authorized Representative/Guardian

WITNESS:_____ DATE:_____

(OMT REV 4/00)