

Consent to Test for Human Immunodeficiency Virus (HIV)

Date:	
Name:	Date of Birth:
Assigned #:	Facility:

I, _____, consent to have my blood tested for the presence of HIV infection.

I understand the following regarding HIV testing:

- The benefits of testing,
- The potential for false positive and negative results,
- The potentially harmful psychological impact of a positive result,
- The importance of additional future testing to rule out infection, and
- Resources and assistance available should the test be positive.

I have been informed that the HIV test results are confidential and will not be released without written permission, except to the Health Care Providers, the facility superintendent or designee, the Medical Director, the Health Care Administrator, and any others as required by law. I have been informed that these people are also required by state law to keep these test results confidential.

I acknowledge that:

- I have read this consent form,
- I have been given the opportunity to ask questions concerning the blood test for HIV infection, and
- My questions have been answered to my satisfaction.

I give my consent to have a blood sample obtained and tested for the presence of HIV infection.

Signature of Person Tested and Date

Witness Signature and Date