



WRITTEN CONSENT FOR HIV ANTIBODY TESTING

Test Subject: _____

I am giving my permission for a blood test in order to detect whether I have antibodies to the HIV virus (Human Immunodeficiency Virus) or any other identified causative agent of AIDS in my blood. I understand that the test results will be used for the purposes of my medical care and treatment.

I understand that the test is performed by withdrawing a sample of my blood and conducting laboratory tests to determine the presence of antibodies to HIV. I understand that the results of the blood tests considered to be positive will be reported to the Illinois Department of Public Health.

I further understand that a positive result does not mean I have AIDS, but that my blood has been exposed to the AIDS virus and antibodies to that virus are present in my blood. I understand that counseling concerning AIDS will be offered to me if my test results are found to be positive.

I have been informed and understand that test results, in a percentage of cases, may indicate that a person has antibodies to the virus when the person does not have the antibodies (a false positive result) or that the test may fail to detect that a person has antibodies to the virus when the person does in fact have these antibodies (a false negative result).

I understand that my test results will be released to my physicians and other health care providers providing my care. In addition, I understand that the law allows my identity and test results to be disclosed to specific persons, such as the physicians and health care providers involved in the use of any donated organs or tissue, and the Illinois Department of Public Health, health care facility staff committees and research studies (without name). I understand that my test results will be kept confidential to the extent provided by law. In addition, I understand that I may withdraw from the testing at any time, prior to the completion of laboratory tests.

My physician has advised me about the purpose, potential uses, limitations and meaning of the test results; the voluntary nature of the test; the right to withdraw at any time, prior to the completion of laboratory tests; and the confidentiality protections under the law. With the information presented above having been completely and clearly explained to me and all of my questions having been answered, I hereby authorize (physician and/or hospital or health care facility) to test my blood for HIV infection.

Signature of Test Subject

Date and time signed - Test Subject

or

Name of a legally Authorized Representative

Signature of a legally Authorized Representative

Date and time signed - Authorized Representative

Name of Physician

Signature of Physician

Date and time signed - Physician

I provided the test subject with a copy of this form in English Spanish Other (Specify) _____
on (Date) - _____ at (Time): _____ .

Printed Name

Title

Signature