# *HIV CONSENT FORM*

I have been offered the blood test for detection of antibodies to the Human Immunodeficiency Virus (HIV) performed by an outside laboratory. HIV is the term used for the virus that produces HIV infection and ultimately causes Acquired Immune Deficiency Syndrome (AIDS).

I understand that this test may not be conclusive because a positive result means additional tests may be needed. A negative result does not necessarily eliminate consideration of AIDS and does not ensure that I do not have any early HIV infection or that I cannot transmit the infection.

I have also been informed that the results of this blood test will only be released to those healthcare personnel and insurance companies providing medical care and coverage to me as allowed by federal and state law. Confidentiality cannot be absolutely guaranteed. The results will also be available to physicians and other health care professionals responsible for my care and treatment.

I understand that these test results will be a part of my medical record. As medical record information, these results will be regarded as confidential and will not be disclosed without my express authorization or as permitted by law.

I understand that not all my health insurance plans will pay for HIV testing. Should my insurance company decline coverage, I understand that I will be expected to pay for it myself.

I also understand that if I am pregnant, knowledge of HIV infection may allow prevention of HIV transmission to my fetus.

I am aware that additional information regarding HIV/AIDS and antibody testing is available at my request, and therefore, acknowledge that I have had the opportunity to ask any questions I have regarding this test prior to giving my consent.

I freely give my consent. Check one of the following:

☐ I hereby give my consent for the performance of an HIV blood test and to the release of results as outlined above.

☐ I refuse consent for the performance of an HIV blood test at this time. I understand that this refusal may limit the information available to my physician.

______________________________
Print Full Name

______________________________ ___________________
Signature Date

3299 Woodburn Road Suite 350 ⬩ Annandale, VA 22003 ⬩ Phone: 703.260.1179 ⬩ Fax: 571.405.6234