# 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 causative agent of Acquired Immune Deficiency Syndrome (AIDS).

I understand that this test may not be conclusive because a positive result means additional tests may be needed and a negative result does not necessarily eliminate consideration of AIDS. 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. I understand that these test results will be a part of my medical record and will be released if I have signed an authorization for release of medical information.

I understand that not al 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 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 hereby give my consent for the performance of the HIV blood test and to the release of results as outlined above.**

_____

Signature Date

_____

Witness Date

**I decline the opportunity for the HIV blood test at this time.**

_____

Signature Date

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Signature Date