# Consent for Performance of Test for HIV Antibodies

I, ______________________________ , understand that a test for antibodies to HIV-1 and HIV-2 viruses will be performed on a sample of my blood.

Dr. ____________________________________ has explained to me the value of knowing the results of the test.

I understand that:

1. The HIV Antibody test is a screening test (sensitive but not completely specific) for antibodies to HIV-1 and HIV-2 viruses in my plasma.
2. This test is NOT diagnostic for the disease of AIDS.
3. If the original test is positive, the test will be repeated in duplicate on the same specimen and if the same result is obtained, the laboratory will report a positive test and will then perform a more specific confirmatory test.
4. The presence of HIV-1 or HIV-2 antibodies is NOT a diagnosis of AIDS, however studies have shown that a high percentage of people who show positive test results will develop AIDS or AIDS-related complex. A positive confirmatory test result means that it is almost certain that I am a carrier of the AIDS virus. If I am a carrier, I can transmit the virus to others by intimate sexual contact, by sharing intravenous needles or by blood and organ donation. A pregnant female can pass the infection to her developing child, and women who are breast feeding can pass the infection to their children.
5. A negative test result does not exclude the possibility of exposure to, or infection with HIV, as the initial test actually identifies the presence of an antibody to the HIV virus. These antibodies may not appear for up to 6 months after initial exposure to the virus.
6. The specimen will be discarded by the laboratory following completion of the above procedure(s).

I also understand that if I would like more information than already provided by my physician, I may ask my physician to request appropriate consultation, or that I may contact the Delaware State Board of Health for counseling and/or testing without revealing my identity and at no cost to me.

I realize that the results of this test will appear on my medical chart and if I should givepermission to release medical information to a third party, the information concerning this test will NOT be withheld. I also understand that the will release the results of this test to the Delaware State Board of Health if required by law.

My signature on this consent form implies that I have read this form, understand all that is stated and voluntarily permit the collection of a blood sample for performance of this test.

I also understand that my consent may be withdrawn if done so before the initial testing is completed.

______________________________________________________________________

Signature of Patient or Legal Representative    Date    Time    Relationship to Patient

______________________________    ______________________________

Witness    Date    Time    Second Witness (Required for Telephoned Comments)    Date    Time

**For Office Use:**

I certify that I have explained to the patient to the extent reasonable and consistent with currently acceptable standards of practice, the need for and nature of the above-named test, pertinent alternatives, consequences and common complications.

______________________________________________________________________

Signature    Date    Print Name