CONSENT TO TESTING FOR HIV ANTIBODIES

I, (patient)_____ hereby give permission to test my blood for presence of the ANTIBODY to the Human Immunodeficiency Virus (HIV), which is associated with Acquired Immune Deficiency Syndrome (AIDS).

I understand that positive results from this test would indicate the presence of ANTIBODIES in my blood which react with the HIV antigen. Positive results do not conclusively indicate whether or not the virus is present in my blood, nor does a positive result mean that I have AIDS. I also understand that a positive result does not predict whether or not I will develop AIDS in the future. If the initial ELISA test is positive, a second ELISA will be performed. If the second ELISA test is positive, a Western Blot will be done to confirm. Only confirmed results will be reported. I understand that this test may be reported to the Public Health Authorities, if required by law.

I understand that a negative result from this test does not conclusively exclude the possibility of infection with HIV virus.

I understand that Kansas City Women's Clinic will take precautions to protect the confidentiality of these ANTIBODY test results. There will be no disclosure to any unauthorized third party without my express written consent and release, other than as required by law.

I understand, however, that the results of this test will be recorded in my medical record and that the results will be released to persons or entities to whom I authorize the release of my medical records.

I understand and agree that the results my be disclosed as necessary to assure appropriate follow-up testing and care of the health care worker exposed to my blood and other body fluids.

After the test results are obtained, my physician will discuss these matters with me and, if necessary, refer me for appropriate medical, psychological, and social counseling.

I have been given the opportunity to ask questions which have been answered to my satisfaction. I have read the above and have had the opportunity to discuss this information and to ask questions. I am aware of the test's limitations and the potential consequences of positive and negative test results. My signature indicates that I give my informed consent to have HIV screening test performed on a sample of my blood.

_____

Signature of Patient (or other Authorized Person) Date

_____

Physician (if consent obtained per physician order) Date

_____

Nurse (if consent obtained due to employee exposure) Date

Patients KCWC A/C # _____ ***DOB:*** _____