Southwest Doctors, PA

Consent for HIV Blood Test

I, ______________________________, voluntarily consent to be tested in order to detect whether or not I have had exposure to the human immunodeficiency virus (HIV), which is the probably causative agent of acquired immune deficiency syndrome (AIDS), by (specific name of physician ordering test). I realize that I can refuse the test. I realize that the test will be performed by withdrawing blood and using a substance to test the blood. I know that my test results are confidential under Texas law, and that unless I specify otherwise, the test result will be released to the physician who ordered the test, and to other persons only as required by law.

Patient ______________________________ Print Name ______________________________

Witness ______________________________ Date ______________________________

Acknowledgment of Counseling

I understand that I have tested positive for the human immunodeficiency virus (HIV), which is the probable causative agent of acquired immune deficiency syndrome (AIDS). I acknowledge that, after receiving my test result, I received immediate face-to-face counseling from (specify name of person providing counseling) about (1) the meaning of the test result, (2) the possible need for additional confirmatory testing, (3) measures to prevent the transmission of HIV, (4) the availability of appropriate health care services, including mental health care, and appropriate social and support services in the area of my residence, (5) the benefits of partner notification, and (6) the availability of the Texas Department of Health Partner Notification Program.

Patient ______________________________ Print Name ______________________________

Witness ______________________________ Date ______________________________

Consent to Release Test Result

I voluntarily authorize the release and disclosure of my test result for the human immunodeficiency virus (HIV), which is the probable causative agent of acquired immune deficiency syndrome (AIDS), to (specify the person or class of persons to whom the test result may be disclosed). The purpose for the release of this test result is: (specify purpose for release). I understand that no additional release of this information will be made without my express written authorization

Patient ______________________________ Print Name ______________________________

Witness ______________________________ Date ______________________________

A PERSON LEGALLY AUTHORIZED TO CONSENT TO THE TEST ON THE PATIENT'S BEHALF MAY SIGN FOR THE PATIENT IF THE PATIENT IS UNABLE TO DO SO OR IS UNDER 18 YEARS OF AGE. THIS FORM COMPLIES WITH THE REQUIREMENTS OF THE COMMUNICABLE DISEASE PREVENTION AND CONTROL ACT, TEXAS HEALTH AND SAFETY CODE, CHAPTER 81.

Prepared by: TMA Office of the General Counsel http://www.texmed.org/pmt/lel/consentformhivtesting.asp