HIV ANTIBODY/ANTIGEN TEST CONSENT
(Written Consent Only Required for Pregnant Patients and Occupational Exposure)

Consent for Testing Patient’s Blood for the Presence of HIV Antibody/Antigen

HIV is an abbreviation for Human Immunodeficiency Virus, the name of the virus which causes AIDS (Acquired Immune Deficiency Syndrome). The HIV antibody/antigen test which will be performed is designed to detect the presence in the blood of the antibody formed by the blood to combat this particular virus and specific viral antigens which may be present shortly after infection.

A positive test indicates that the person has probably been infected with HIV at some time in the past. It is not a test for the amount of HIV virus itself. The presence of HIV antibody/antigen does not mean that the person will get AIDS. At this time, it is not possible to predict whether AIDS will develop in a person who has been infected with the virus and has developed antibodies. Research is now going on which may in the future answer that question and determine what factors, other than exposure to the HIV virus, might affect the risk.

This test is not 100% accurate, but it is reliable in most cases. There are occasional false-positive results. False-positive tests mean that the tests are positive, but they are positive for reasons other than the presence of HIV antibody/antigen. The following precautions will be taken to minimize the possibility of a false-positive test. Blood specimens which are positive by one test method will be tested by a second test method. Positive test results will not be reported to my physician or me until at least two tests have been performed.

The test also has a small number of false-negative results, meaning that the test results are negative, but the person may nonetheless have been infected with HIV in the past. Although the reported incidence of both false-negative and false-positive tests has been small, the existence of such results indicates that while the test is generally accurate, it is not perfect.

I have been informed of the need for and limitations of HIV antibody testing, that positive results will be confirmed, that counseling is available, and that the test results will be made part of my permanent medical record, both paper and electronic. I understand the benefits and risks of testing and the meaning of a negative, positive and indeterminate test result as explained to me by a health care provider. I understand that HIV infection is a reportable condition in Massachusetts. I understand that if I have a positive test result, my doctor or the hospital is required to report my name to the Massachusetts Department of Public Health.

For Occupational Exposures: If I am the source patient, I understand that the result of this test will also be disclosed to the exposed healthcare worker(s) for the purposes of allowing him/her to receive the appropriate counseling and medical treatment. In this situation, I will not be charged for this test.

I understand that the test for HIV antibody is a voluntary one; I have the right to decline testing. If you do not understand the information above, please ask your health care provider for further explanation.

If you have read and understand this material, please sign below (or indicate verbally) that you give consent to be tested for the presence of HIV antibody/antigen and for the release of the results of the test to the ordering health care provider, his/her designee, your personal physician, and to any facility to which you may be transferred.

Patient Name  (Please print)  Witness to signature

Patient Signature  (Not required if verbal consent given)  Date  Time

For Pregnant Patients: I realize this information may be valuable in treating my baby and consent to release this information to my baby’s medical record and physician.

Patient’s Signature  (required if applicable)  Witness to signature  Date  Time

Note: A signature is required to release results to a baby’s medical record, verbal consent is not sufficient.
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