MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
CONSENT FORM FOR THE
HUMAN IMMUNODEFICIENCY VIRUS (HIV) ANTIBODY TEST

I have been informed that my blood obtained from a finger stick or vein, a urine sample, or an oral sample from my mouth, will be tested for antibodies to the Human Immunodeficiency Virus, the virus that causes AIDS.

I acknowledge that I have been given an explanation of the test, including its uses, benefits, limitations and the meaning of test results.

I have been informed that the HIV test results are confidential and shall not be released without my written permission, except to: _____* and as permitted under state law.

I understand that I have a right to have this test done without the use of my name. If my private physician does not provide anonymous testing, I understand that I may obtain anonymous testing at any Michigan Department of Community Health-approved HIV counseling and testing site.

I understand that I have the right to withdraw my consent for the test at any time before the test is complete.

I acknowledge that I have been given a copy of the pamphlet "*What You Need to Know about HIV Testing*." I have been given the opportunity to ask questions concerning the test for HIV antibodies, and I acknowledge that my questions have been answered to my satisfaction.

By my signature below, I consent to be tested for HIV.

_____ _____
Patient/Parent/Guardian Signature Date

_____ _____
Witness Date

AT THIS TIME, I DO NOT WANT TO BE TESTED FOR THE HUMAN IMMUNODEFICIENCY VIRUS

_____ _____
Patient/Parent/Guardian Signature Date

_____ _____
Witness Date

* Please write in the physician or health facility name who will receive the HIV test results

Original - FOR RECORDS

MDCH is an Equal Opportunity Employer, Services and Programs Provider
DCH-0675CF
Authority: P.A. 368/1978

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Witness Date

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Patient/Parent/Guardian Signature Date

_____ _____
Witness Date

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Original - FOR CLIENT

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