Physician______________________________

I, _____________________________________, understand that a blood test is to be performed to determine my HIV (Human Immunodeficiency Virus) antibody, and/or HEPATITIS B VIRUS antibody status. This test or tests are being conducted:

HIV:	[ ] Diagnostic purposes	[ ] Employee exposure
HEPATITIS B VIRUS:	[ ] Diagnostic purposes	[ ] Employee exposure

HIV is the cause of AIDS (acquired Immunodeficiency Syndrome). The possible risks and benefits of having the test results have been informed that this test does not in itself diagnose whether I have or will get AIDS. While the test is accurate, it is not perfect, and may miss an early case.

In the case of HIV, a confirmed positive test result means that the testing laboratory (VIROMED) has tested my blood sample by two methods. One Enzymed-Linked Immunosorbent Assay (ELISA) test has been performed, and one confirmatory test (WESTERN-BLOT). Only after both tests have been performed will a positive result be released to my physician.

Reporting Requirements: I understand that this consent form and the test results will be kept in my medical record. Under North Dakota law my test results may be made available, without my consent, to my parents, if I am a minor, to my guardian if I am incapacitated, health care providers involved in my on going medical care, blood banks, organ donor programs, the State Health Department, morticians, researchers, health care review organizations, under lawful court order, or with my written consent for North Dakota Department of Health and Consolidated Laboratories. I will be requested to identify those individuals whom I may have exposed either through the sharing of intravenous drug needles or through sexual contact.

The meaning of the test and its interpretation has been explained and I have been informed that I can ask questions about it at any time. I also understand that other information about this test and counseling is available to me upon request.

______________________________ ______________________________

Date Time Patient/Guardian Signature

This consent expires one year from the above date unless other designated______________________________.

Relationship to Patient:______________________________

Witness:______________________________

CONSENT AND AUTHORIZATION TO DISCLOSE INFORMATION REGARDING HIV TESTING AND RESULTS

I hereby consent to disclosure and authorize release of information regarding my testing for the HIV virus, including the results of the testing to my insurance carrier and any other person I designate below. I understand that it is my right not to disclose this information to any persons or entities other than those listed above in the informed consent section of this form, but I have decided to authorize this disclosure of my own free will and accord.

____

Designee

____

Designee

____

Designee

____

Patient Signature

____

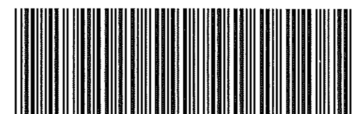
Witness

WHITE COPY - File in Chart YELLOW COPY - Send to lab with patient

HIV and/or Hepatitis B Virus Testing Consent

Charted by:______________

Informed Consent Form HIV and/or Hepatitis B Virus Testing



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