HIV Antibody Testing
SAMPLE Confidential Informed Consent Form

The HIV antibody test is a blood or cheek swab test to detect whether or not a person has HIV antibodies in his or her blood. HIV (Human Immunodeficiency Virus) is the virus that causes AIDS (Acquired Immune Deficiency Syndrome).

Records of this test will be maintained in confidential files at (name of facility). Only authorized personnel will have access to this information.

Authorized (name of facility) staff at the state, district, and local levels may legally release the results of this test to the following:

- ✓ You, the consumer
- ✓ The parent, legal guardian, or person/agency granted custody of a minor or incompetent client.
- ✓ The person or legal entity named on an *Authorization for Release of Information* form signed by you, or by the parent or guardian of a minor or incompetent client.
- ✓ A health care provider who has a legitimate need to know such information to provide immediate and specific health care services to you.

It is our standard of care that your blood sample or oral swab be processed confidentially. This information may be compiled, confidentially, for public health statistics or for the purpose of research. Note: although your name is a required part of such information, the name itself will be translated into a code which will be used to distinguish your testing data from that of others. Your testing data will not be identified by name in public health statistics or in any research.

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I have read the information on this sheet. I was given an opportunity to ask questions and I understand the information printed here. Circle: Yes No

I give permission for (name of your facility) to collect one or more blood samples or oral specimens from me in order to detect whether or not I have HIV antibodies in my bloodstream.

I request the HIV antibody test ____

(Client Signature)

______________________________ ______________________________

(Parent/Guardian Signature) (Relationship)

Test results will be discussed with me privately and I will be given appropriate referrals as needed.

Date: ________________ Counselor/Witness: ____________________________________

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