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CONSENT FOR HIV BLOOD TEST

I voluntarily consent to be tested in order to detect whether or not I have been exposed to the human immunodeficiency virus (HIV), which is the probable causative agent of acquired immune deficiency syndrome (AIDS). I realize that I can refuse the test. If the results from the Path Lab are positive, I agree to additional testing which may occur on the sample I provide today to help confirm my HIV status. The cost of the test is $77. **If insurance information is not provided I am financially responsible for this additional testing.**

Patient ______________________________________ Date ______________________

Witness _____________________________________ Date ______________________

IF TEST RESULTS ARE POSITVE WHAT YOU SHOULD EXPECT.

A. We are required by law to contact The State office of Public Health with your results.
B. The State office of Public Health will contact and counsel you on treatment options and prevention of spreading the disease.
C. The State office of Public Health may assist you in notifying and referring your partners for medical services without giving your name to your partners.

***** You must initial only one of the two boxes below to indicate your consent for us to inform your physician on record if your HIV test is positive.***

☐ I agree to allow the Path Lab to inform my physician on record if my HIV test is positive.

☐ I do not agree to allow the Path Lab to inform my physician on record if my HIV results are positive.

I refuse to have my blood collected for HIV today.

Patient ______________________________________Date ______________________

Witness ______________________________________Date ______________________

"Providing High Quality Pathology Services, With Superior Customer Satisfaction"