



## CONSENT FOR TESTING OF HIV ANTIBODIES

**Florida State Law requires that each health care provider offer counseling and request patient consent prior to HIV screening**

Screening for HIV involves a blood sample to detect the presence of antibodies to the Human Immunodeficiency Virus (HIV), which is associated with Acquired Immune Deficiency Syndrome (AIDS).

I understand that positive results from this test would indicate the presence of antibodies in my blood which react with the HIV antigen. Positive results do not conclusively indicate whether or not the virus is present in my blood, nor does a positive result mean that I have AIDS. I also understand that a positive result does not predict whether or not I will develop AIDS in the future.

I understand that a negative result from this test does not conclusively exclude the possibility of infection with the HIV virus. All positive test results will be confirmed by a second confirmatory test.

I understand that **Advanced Women's Health Specialists** will take precautions to protect the confidentiality of these antibodies test results. There will be no disclosure to any unauthorized third party without my written consent and release, other than required by law.

I understand, however, that the results of this test will be recorded in my medical record and that the results will be release to persons or entities to whom I specifically authorize the release of medical records.

I specifically agree to release test results to applicable third-party payers in order to obtain reimbursement for my medical expenses.

I also understand and agree that the results may be disclosed as necessary to assure appropriate follow-up testing and care of healthcare worker who may be exposed to my blood or other body fluids.

After the test results are obtained, my physician will discuss these matters with me and if necessary, refer me to appropriate medical, physiological and social counseling.

I have been given the opportunity to ask questions which have been answered to my satisfaction. I have read and understood the information above. I am aware of the test's limitations and the potential consequences of positive and negative test results. My signature indicated that I give my informed consent to have the HIV screening test.

\_\_\_\_ I hereby **DO** give permission to test my blood for presence of antibodies to the Human Immunodeficiency Virus (HIV), which is associated with Acquired Immune Deficiency Syndrome (AIDS).

\_\_\_\_ I hereby **DO NOT** give permission to test my blood for presence of antibodies to the Human Immunodeficiency Virus (HIV), which is associated with Acquired Immune Deficiency Syndrome (AIDS).

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date