



**INFORMED CONSENT TO DO AIDS VIRUS (HIV)  
ANTIBODY TEST AND TO RECORD TEST RESULTS**

AA0000  
NAME, PATIENT

FORM  
M3142  
08/01  
13885

The HIV antibody test detects the presence of antibodies to the AIDS virus. These antibodies are substances in the blood produced by the body following infection with the AIDS virus. A positive test does not necessarily mean you have AIDS. A positive test, if confirmed, does suggest infection by the virus or acquisition into your body.

I have been informed about the HIV antibody test and have been counseled as to the implications of a positive test result and a negative result. I have had an opportunity to ask questions which were answered to my satisfaction. I understand that if my test is positive, it may help my physician give me more appropriate medical care. I understand that this test result will be part of my medical record. I understand that both my test results and my medical record are confidential and will be shared only with health care providers directly involved in my care or others that I authorize to have access to my records. I understand that if my test result is positive, my physician is obligated by law to report my name to the State Health Department which will in turn contact me about counseling for my spouse and/or sexual partners and/or persons with whom I have shared needles. I understand the benefits and risks of the test. I agree to have this test done.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

Yes

No

This test is being performed for follow-up of a Health Care Worker's exposure to blood or body per hospital policy.