ACKNOWLEDGMENT AND CONSENT FOR HIV ANTIBODY BLOOD TEST

I acknowledge that I have been informed by my physician that my blood will be tested in order to detect whether or not I have antibodies in my blood to the human immunodeficiency virus (HIV), which is the probable causative agent of Acquired Immune Deficiency Syndrome (AIDS). I understand that the test is voluntary and that it is performed by withdrawing blood and using a substance to test the blood. I understand that I have the right to consent or refuse testing.

I acknowledge that I have been informed that the test is new and its accuracy and reliability are still uncertain. Test results, in some cases, indicate that a person has antibodies to the virus when they actually don't (false positive). The test may fail to detect that a person actually does have the antibodies to the virus (false negative). I acknowledge that I have been informed that a positive blood test doesn't mean that I have or will develop AIDS.

I acknowledge that I have been informed that any questions regarding the nature of the blood test, its expected benefits, or alternate tests may be asked of my physician before I consent to the blood test. I have had the opportunity to ask my physician regarding this procedure and she has fully answered my questions.

I understand that the results of this blood test will only be released to the physician directly responsible for my care and treatment and no other persons as required by law. I further understand that no additional release of the results will be made without my express written authorization.

By my signature below, I acknowledge that I have been given all of the information I desire concerning the blood test and release of the results. I hereby give my consent to the performance of a blood test to detect antibodies to HIV.

_______________	___________________________________
Date	Signature of Patient or Legal Guardian
	___________________________________
	Print Name

WITNESS:

_______________	___________________________________
Date	Signature
_______________	___________________________________
Date	Signature of Attending Physician