Fairfax OB-GYN Associates, Inc.
An Advantia Health Company

Informed Consent Form for HIV Antibody Test

1) I, _____, have been advised by my health care provider to have a blood test to detect the presence of antibodies to the HIV, the virus that causes AIDS. I understand that the blood test for the virus which is the probable cause of AIDS are not 100 percent accurate, and that these blood test results sometimes produce false positive or false negative results. I have been informed that a positive result will necessitate further testing to confirm the results. I further understand that the presence of the antibodies does mean that a person has been infected with the AIDS virus but does not necessarily mean that a person will develop AIDS.
2) I have been informed of the procedure for taking blood and the possible risks and consequences of such a procedure.
3) I have been informed about the nature of the blood tests, their expected benefits and risks, and have been given the opportunity to ask any questions about the blood tests.
4) I understand that my health care provider will notify me face to face of the results of my blood tests and that the results will be explained to me. I understand that the results can not be given over the phone! I further understand that my test results will be recorded in my medical record.
5) Fairfax OB-GYN Associates, Inc., to the best of our ability, will not disclose the results of these tests to others, except to the extent required by law or except to the extent such disclosure is required in order to safeguard the well-being of patients and employees at Fairfax OB-GYN Associates, Inc, or other persons at risk. Virginia law requires that the health care provider notify the Virginia Department of Health if an individual test positive for exposure to HIV.

I authorize Fairfax OB-GYN Associates, Inc., and anyone authorized by them to perform the blood tests for the HIV.

Patient Printed Name: _____

_____ _____
Patient signature **Date**

_____ _____
Witness **Date**