

SOUTHEAST VALLEY OBSTETRICS & GYNECOLOGY, PLC
480-464-2101

CONSENT FOR HIV TESTING

I have been given the opportunity to ask questions and have had my questions answered to my satisfaction. I understand that this test can be performed anonymously at a public health agency. I also understand that I may withdraw my consent at any time before a blood sample is taken. I also understand that this is a voluntary test and I have a right to refuse to be tested.

I understand that if the HIV test results are positive, the physician or facility representative conducting the test will make reasonable efforts to notify me of the results at the address or phone number I have provided, and will provide or arrange for counseling as required by Arizona State law and regulations regarding (1) the HIV (2) AIDS, (3) appropriate precautions to reduce the likelihood of transmission of the virus to others. I agree to assume all risks that may result if I cannot be contacted.

I understand that Arizona state law and federal regulations require that if my test results are positive, they will be submitted to the local and state and federal health departments.

I also understand that the physician or facility may report to the Arizona Department of Health Services identifiable third parties such as a spouse or sex partner who may be at risk of contracting the virus if I do not release this information. Finally, I understand that the test results may be placed in a medical record kept by the facility or person administering the test and that persons involved in providing or paying for my health care may access this information.

My signature below indicates that I have received and understand the information I have been given and I voluntarily consent to and request HIV testing.

Patient/subject name (Printed)

Patient/Legal representative signature

Date

Witness