



Please print clearly

Patient Name: _____

Address: _____

Date of Birth: ___ / ___ / ___ Sex (please circle): M F

Ordering Physician: _____

Informed Consent for HIV Testing

My signature below indicates that:

1. I agree to be tested for HIV.
2. I have been given information about the test, including the limitations of the test and the test results.
3. All of my questions about the test have been answered.
4. I understand that the test, including the results, will become part of my medical record, including the electronic medical record and that authorized UMMMC personnel can view these results. I understand that confidentiality will be maintained to the extent possible and that the test results will be released as described in this consent and as mandated by state or federal law or with my written consent.
5. The charges for this testing, with an indication of the testing performed, will be submitted to my health care insurer, except for self-pay serology testing, which may be arranged through the UMMMC HIV Counselor.
6. My decision to be tested is completely voluntary.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS.

Signature of Patient/Authorized Representative

Date

Witness to Signature

Date

If Authorized Representative, print name and relationship to patient:

Name

Relationship

If interpreter utilized, Name of Interpreter: _____

If consent is obtained by telephone (for physician office use only):

Signature of Witness

Printed Name of Witness

Date