



**Consent for Testing Blood**

**To Detect Antibodies to the**

**Human Immunodeficiency Virus (HIV)**

I have been informed that my blood will be tested for antibodies to the Human Immunodeficiency Virus (HIV), the probable agent of AIDS. I have been informed about the limitations and implications of the test. I have had a chance to ask questions which were answered to my satisfaction. I understand that the test's accuracy and reliability are not 100 percent certain.

I have been informed that the test is performed by withdrawing blood from my arm and testing the blood specimen.

By my signature below, I acknowledge that I have been given information concerning the benefits and risks, and that I either accept or decline to have my blood tested for antibodies to the HIV.

\_\_\_\_\_  
Patient Name (Please Print)

\_\_\_\_\_  
Date

Accept: \_\_\_\_\_  
Patient/Guardian Signature

Decline: \_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Relationship to Patient

*"A Practice Specializing in Women's Health Care"*