



CONSENT IN ORDER TO MAKE THE TEST OF THE HIV

Patient's name: _____

I recognize that I have received information with respect to the test of the HIV, a virus that has been associated to the Acquired Immune Deficiency Syndrome (AIDS). I have been informed about the nature of blood test for the detection of the virus, as well as its benefits and risks. I understand that the information that has been provided to me and the blood test to detect the HIV are not 100% secure. The blood tests some times give results false positive or false negatives. I also realize that a positive test of HIV means that a person has been probably infected with the virus, but does not mean necessarily that this person developed it. I recognize that if a person develops the virus, or gets sick with the virus, a person infected with the virus can still transmit the virus to other people who might become sick. Therefore, knowledge about the presence or absence of infection is important, to protect the people who have direct bonding with me.

I recognize that HIV test results will become part of my/the patient's permanent hospital record and that this record will be available to members of the hospital and medical staff who are implied in my/the patient's treatment, to other individuals in the hospital who require access to the records for management purposes, and to insurance companies or the third party payers responsible for charges incurred during this treatment. However, the contents of the hospital record will not be revealed to other third parties, unless written permission for disclosure has been given, or disclosure is authorized or required by law.

I understand that I will be notified of the test results and that I will receive post-test counseling. On this basis, I hereby consent to the performance of HIV test(s) for me/the patient.

—

Patient's signature

Date

Witness