CAPITAL WOMEN'S CARE

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INFORMED CONSENT AND AGREEMENT TO HIV TESTING

I understand the following information, which I have read or has been read to me:
• Blood, or another body fluid or tissue sample, will be tested for human immunodeficiency virus (HIV) infection;
• Consent to be tested for HIV, the virus that causes AIDS, should be given FREELY;
• Results of this test, like all medical records, are confidential, but confidentiality cannot be guaranteed; and
• If positive test results become known, an individual may experience discrimination from family or friends and at school or work.

What a NEGATIVE Result Means:
• A negative test means that HIV infection has not been found at the time of the test.

What a POSITIVE Result Means:
• A positive HIV test means that a person is infected with HIV and can transmit the virus by having sex, sharing needles, childbearing (from mother to child), breastfeeding, or donating organs, blood, plasma, tissue, or breast milk.
• A positive HIV test DOES NOT mean a diagnosis of AIDS -- other tests are needed.

What Will Happen if the Test Is Positive:
• A copy of the Department of Health and Mental Hygiene's publication "Information for HIV Infected Persons" will be provided; • The health department or my doctor will offer advice about services that are available;
• Women who are pregnant or may become pregnant will be told of treatment options which may reduce the risk of transmitting HIV to the unborn child;
• Information will be provided on how to keep from transmitting HIV infection;
• My name will be reported to the health department for tests that indicate HIV infection. This includes, but is not limited to: HIV Antibody (Western blot), HIV Viral Load (RNA or DNA quantification), HIV viral sequencing or HIV p24 antigen tests;
• My name will be reported to the health department if my doctor finds that I have AIDS;
• I will be offered assistance in notifying and referring my partners for services. If I refuse to notify my partners, a doctor may notify them or have a representative of the local health department do so. If a representative of the local health department notifies my partners, my name will not be used. Maryland law requires that when a local health department knows of my partners, it must refer them for care, support, and treatment.

I have been given a chance to have my questions about this test answered. I hereby agree to be tested for HIV infection. Print name of individual to be tested in the boxes below:

First Name MI

Last Name

Patient Signature Date

Signature of Counselor or Health Care Provider Date