Tequesta Family Practice

395 Tequesta Dr.
Tequesta, FL 33469
(561) 746-4333 VOX
(561) 746-4449 FAX
R. J. Oenbrink, DO
www.tequestafamilypractice.com

PATIENT CONSENT FORM TO TEST FOR AIDS

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I, Testyapatient Testyapatient have been advised by my physician(s) to have a blood test to detect the presence of antibodies to the Human Immunodeficiency Virus (HIV), the virus that causes Acquired Immunodeficiency Syndrome (AIDS). I have been advised that the procedure, which involves the withdrawal by needle of a small amount of blood for laboratory testing (about 1/2 tablespoons) may cause some discomfort at the site of the entry of the needle, and that the procedure has some risks, including, but not limited to, bruising, soreness, and a risk of infection.

2. I have been provided with information about the test for antibodies to the HIV virus, about the HIV virus, and about AIDS, and I have been given the opportunity to ask questions regarding this information and have my questions answered. I have been informed by my .physician(s) that the test, in the opinion of the physician(s), is important both to my health care and to ensure that appropriate evaluation can be undertaken and adequate precautions taken to prevent transmission of the virus to others.

3. I have been informed by my physician(s) that if my test results are positive, it may be necessary to take infectious disease precautions about which my physician will provide me more detailed information. I have been informed that if I decline permission for this test, decisions whether to take infectious disease precautions will be made an the basis of other medical information concerning me. I have been informed that if I refuse permission for the HIV antibody test, my health care, including diagnosis and treatment, may be adversely affected.

4. My physician(s) have informed me that if I consent to have the test done, it is important, both for my health care and for the health of others who will be providing care to me, that the test results be placed in my health record, and that the health record is the most accurate way for all health care providers involved in a patient's care to be fully informed of a patient's diagnosis and the treatment. Therefore, if I agree to have the test done, the results of the test will be recorded in my health record and persons involved in my health care will have access to that information. If I am pregnant, the results of this test will become a part of my baby's medical record.

5. I have been informed that the performance and results of the HIV antibody test are considered confidential. I have been informed by my physician(s) that the test results are in my health record but shall not be released except to the individuals and organizations that have been given access by law to these records or information, or those individuals or entities which I have given authorization to release my health record to either upon or subsequent to admission.

6. If I do not consent to the HIV antibody test, I agree to assume all risks that may result from my refusal to consent. I also agree not to hold my physician(s), the hospital or other personnel responsible for any adverse results that may arise from my refusal to consent to the HIV antibody test.

7. The test results will be given to me by my physician.

8. I understand the benefits and risks and: Do CONSENT/DO NOT CONSENT to the HIV antibody test. (Check one to respond).

SIGNATURE OF PATIENT:_____

WITNESS:_____

PHYSICIAN SIGNATURE:

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