SUNSHINE PEDIATRICS
DR. PAYAL PATEL
18934 N. DALE MABRY HWY #101
LUTZ, FL 33548
P: (813) 948-2679

I_____ have been advised by my physician to have an HIV blood test to detect the presence of Antibodies to the Human Immunodeficiency Virus (HIV), the virus that causes Aquired Immunodeficiency Syndrome (AIDS). I have been advised that the procedure involves the withdrawal by needle of a small amount of blood for laboratory testing, and my cause slight discomfort at the sight of entry of the needle. The procedure has minimal risks, such as bruising, soreness and slight infection.

I have been provided with information about the test for antibodies, including the possibility of a false negative or false positive test. I understand that the HIV test is intended to detect infection with the HIV virus, not diagnose the disease of AIDS. I also understand that a positive HIV test does not mean that I have AIDS and that other means of diagnosis must be used in conjunction with the blood test.

I have been informed that the performance and results of the HIV antibody test are considered confidential. I understand that the results in my health records shall not be released without my written permission except to those individuals who are involved in my care and individuals and organizations that have been given access to the results by law. Those individuals or organizations include, Public Health Authorities.

I understand my physician will advise me of the results of my HIV test.

I have been informed that if I refuse permission for the HIV test, my healthcare, including diagnosis and treatment may be affected.

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 acknowledge that I have read and understand this consent form. I have had the opportunity to ask and have answered any questions.

I do_____ I do not_____ (check one) consent to the performance of the HIV antibody test.

___________________________ ___________________________

Date/Time Signature

____

Witness

**If the patient is under 13 years of age or unable to consent, consent to be signed by parent/guardian.*

COMPLETE THIS SECTION ONLY IF TESTING DUE TO A HEALTH CARE WORKER EXPOSURE I UNDERSTAND I HAVE REQUESTED TO HAVE AN HIV TEST BECAUSE A HEALTH CARE WORKER HAS BEEN EXPOSED TO MY BLOOD OR OTHER BODY FLUIDS. I UNDERSTAND THE HEALTH CARE WORKER WILL BE INFORMED OF THOSE RESULTS: HOWEVER: FOR TESTING PURPOSES OF A HEALTH CARE WORKER EXPOSURE, THE PUBLIC HEALTH AUTHORITIES WILL NOT BE INFORMED OF MY NAME, UNLESS I HAVE GIVEN PERMISSION.

____

Signature