I voluntarily give my consent to be tested for exposure of the Human Immunodeficiency Virus (HIV). HIV is the term used for the virus that is thought to cause AIDS. I understand that my blood will be drawn for the purpose of determining whether I have been exposed to this virus.

I understand that the exact meaning of an HIV antibody test result may not be clear in my case. A positive result does not mean that I will come down with AIDS. A negative test does not ensure that I do not have early HIV infection or that I cannot transmit the infection.

I understand that all reasonable efforts to provide confidentiality and/or anonymity to the extent provided by law will be made. However, I understand that the results of this test will be recorded in my medical record. As Medical record information, these test results will be regarded as confidential, and the Hospital will not disclose these test results to unauthorized third parties without my express written authorization. I understand, however, that confidentiality cannot be absolutely guaranteed, and that the results will be available to physicians and other health care professionals responsible for my care and treatment. I understand positive results by law will be reported to the Public Health Department where reasonable efforts will be made to enlist my assistance in partner notification.

I have been informed that if this test is positive a physician will provide counseling for the follow up care and for precautions against transmitting this infection.

I understand that if I refuse this test my exposure to HIV will remain unknown. My ability to infect others with this virus will also remain unknown.

I warrant that I freely give my informed consent and that I have not been forced, coerced or subjected to any constraint or inducement. I understand that I may withdraw this consent anytime prior to having my blood drawn.

I hereby give consent for the performance of the HIV antibody test.

I refuse consent for the performance of the HIV antibody test. I understand that this refusal may limit the clinical data available to my physician. However, this refusal will not affect my access to further care.

DATE	TIME	SIGNATURE OF PATIENT

SIGNATURE OF COUNSELOR

(10/17/11)

CATHOLIC HEALTH INITIATIVES

Franciscan Health System

St. Joseph Medical Center, Tacoma, WA
St. Francis Hospital, Federal Way, WA
St. Clare Hospital, Lakewood, WA
St. Elizabeth Hospital, Enumclaw, WA
St. Anthony Hospital, Gig Harbor, WA

CONSENT FOR HIV ANTIBODY TEST

Patient Information