HIV CONFIDENTIAL CONSENT Test ID #
State Form 53137 (R1/8-08)
INDIANA STATE DEPARTMENT OF HEALTH
WABASH VALLEY PATH
DISCIPLES HIV-AIDS MINISTRY

HIV CONFIDENTIAL CONSENT

By agreeing to have an HIV antibody test performed on the blood/oral specimen taken from me at this Counseling, Testing and Referral site:

1. I affirm that I am 13 years of age or older.
2. I understand that the HIV antibody test is being done confidentially. It is my responsibility to contact this CTR in person to obtain my test result.
3. I understand that if a blood sample is taken, I may have slight discomfort and a small bruise may develop at the site of entry of the needle.
4. I understand that a positive HIV test result does not mean that I have AIDS.
5. I understand that a negative HIV test result does not mean that I am not infected because it can take 3 months for the body to produce enough HIV antibodies for the test to indicate infection.
6. I understand that a positive test result could cause psychological stress for me and could be used to discriminate against me should it not be kept confidential.
7. I understand that if my HIV test result is confirmed positive, I will be counseled as to my duty to notify my past and present sex and/or needle sharing partners, including any spouse (defined by Public Law 104-146 as "any individual who is the marriage partner of an HIV-infected patient or who has been the marriage partner of that patient any time within the 10-year period prior to diagnosis of HIV infection) of my HIV positive status so they may arrange medical care. I will also be counseled as to my duty to notify all current and future sex and/or needle-sharing partners of my HIV positive status prior to engaging in behavior which may put them at risk per Indiana law. I understand my counseling will also include my inability to donate body fluids and tissues or sign a donor card or document. In addition, I will be informed of the benefits of early medical treatment.
8. I understand that if I feel I cannot contact or locate my past and/or present sex and/or needle-sharing partners for any reason that a trained Disease Intervention Specialist (DIS) will assist me by confidentially notifying my partners and advising them of the need for medical care.
9. I understand that if I am assisted by a DIS, my name will remain anonymous and that no details about my identity will be revealed to my partners under any circumstances.
10. Confidentiality has been explained, as well as my rights if I feel I have been discriminated against, in accordance with the law.
11. I have read this form thoroughly and my questions have been answered to my satisfaction. I hereby consent to the taking of a blood/oral sample from me in order to perform screening and confirmatory tests for HIV antibody.

Signed _____ Date *(month, day, year)* _____

Witness _____ Date *(month, day, year)* _____