MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Number, and Edition Date.

REQUIRING DOCUMENT *(Title and Number)*	ISSUANCE DATE
SAFETY AND OCCUPATIONAL HEALTH PROGRAM, NAVHOSPCAMPENINST 5100.6J	15 NOV 2006

LOCAL FORM TITLE *(Optional)*

CIVILIAN CONSENT FOR HEPATITIS AND HIV ANTIBODY TEST

I am consenting to be tested for hepatitis and the Human Immunodeficiency Virus (HIV). This test will only be done in the event of a healthcare worker being significantly exposed to my body fluid(s). I understand that withholding my consent will in no way affect my care or eligibility for care at this facility.

I have been informed that my blood can be tested in order to detect whether or not I have antibodies to the HIV virus, which is the causative agent of Acquired Immune Deficiency Syndrome (AIDS). I understand that the test is performed by withdrawing blood and using a substance to test the blood. I have been informed that the test results may, in some cases, indicate that a person has the antibodies to the virus when the person does not (false positive) or fail to detect that a person has antibodies to the virus when the person has antibodies (false negative). I also have been informed that a positive blood test result does not mean that I have AIDS and that in order to diagnose AIDS other means must be used in conjunction with the blood test.

I have been informed that if I have any questions regarding the nature of the blood test, its expected benefits, its risks, and alternate tests, I may ask those questions before I decide to consent to the test.

I understand that the results of this blood test will only be released to those health care practitioners directly responsible for my care and treatment. I further understand that no additional release of the result will be made without my written authorization.

☐ I GIVE CONSENT for the performance of the blood test to detect hepatitis and antibodies to the HIV virus if a health care worker is exposed to my body fluids. By my signature below I acknowledge that I have been given all of the information desire concerning the blood tests and release of the results, and have had all my questions answered satisfactorily.

☐ I DO NOT WISH to have my blood tested for hepatitis or the HIV virus. I am assured that this will not affect my care. By my signature below I acknowledge that I have been given all of the information I desire concerning the blood test and have had all of my questions answered.

NAME: _____ SIGNATURE: _____

DATE: _____ TIME: _____ WITNESS: _____

PRACTITIONER'S NAME	PRACTITIONER'S SIGNATURE	DATE
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*	HOSPITAL OR MEDICAL FACILITY	STATUS
	DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
	SPONSOR'S NAME	SSN
	RELATIONSHIP TO SPONSOR	