WE MAKE LIVES BETTER
UT HEALTH SCIENCE CENTER™
SAN ANTONIO

Consent to HIV Testing Due to Exposure
Of a Health Care Worker

I, _____, hereby give permission to the UTHSCSA to draw and test my blood for the presence of HIV antibody which is associated with Acquired Immune Deficiency Syndrome (AIDS).

I understand that I have been requested to have this test because a worker in a UTHSCSA clinic has been exposed to my blood or body fluid and because the United States Center for Disease Control and Prevention and the Texas Department of Health recommend testing of patients following such exposure. I understand that this test, in itself, is not diagnostic for AIDS. I understand that positive results from this test indicate the presence of antibodies in my blood which react with the HIV (AIDS) virus. Positive results do not conclusively indicate whether or not the virus is present in my blood, nor does a positive result mean that I have AIDS. I also understand that a positive result does not predict whether or not I will develop AIDS in the future. I understand that a negative result from this test does not conclusively exclude the possibility of infection with the HIV (AIDS) virus.

All positive test results will be confirmed by repeating the same test, a control for performance or laboratory error. The initial confirmation will not be performed by the Western Blot method which is more accurate and may be recommended for subsequent confirmation. I understand that a positive result from this test will be reported to the Texas Department of Health as required by law. I understand that UTHSCSA will take precautions to protect the confidentiality of these antibody results. There will be no disclosure to unauthorized third party without my express written consent. I understand; however, that the results of this test will be recorded in my medical record and that the results will be released to persons or entities to whom I authorize the release of my medical record, unless I expressly deny permission to release this test result.

I understand that a waiver of the privilege of confidentiality and privacy of my medical records in order to gain insurance reimbursement means that the results of this test will be disclosed unless I expressly deny permission to release this test result. I understand and agree that the results may be disclosed as necessary to assure appropriate follow-up testing of the health care worker exposed to my blood or other body fluids.

After the test results are obtained, my physician will discuss these matters with me and, if necessary, refer me for the appropriate medical, psychological, and social counseling. I have been given the opportunity to ask questions which have been answered to my satisfaction. I have read the above and had the opportunity to discuss this information with _____. I am aware of the test's limitations and the potential consequences of positive and negative test results. My signature indicates that I give my informed consent to have blood drawn and to have the HIV screening performed.

_____ _____

Patient's Signature Date Witness Date