**INFORMED CONSENT AND AGREEMENT TO HIV TESTING**

***I understand the following information, which I have read or has been read to me:***

* Blood, or another body fluid or tissue sample, will be tested for human immunodeficiency virus (HIV) infection;
* Consent to be tested for HIV, the virus that causes AIDS, should be given FREELY;
* Results of this test, like all medical records, are confidential, but confidentiality cannot be guaranteed; and
* If positive test results become known, an individual may experience discrimination from family of friends and at school or work.

**What a NEGATIVE Result Means:**

A negative test means that HIV infection has not been found at the time of the test.

**What a POSITIVE Result Means:**

* A positive HIV test means that a person is infected with HIV and can transmit the virus by having sex, sharing needles, childbearing (from mother to child) breastfeeding, or donating organs, blood, plasma, tissue, or breast milk.
* A positive HIV test DOES NOT mean a diagnosis of AIDS – other tests are needed.

**What Will Happen if the Test Is Positive:**

* A copy of the Department of Health and Mental hygiene’s publication “information of HIV Infected Persons” will be provided;
* The health department or my doctor will offer advice about services that are available;
* Women who are pregnant or may become pregnant will be told of treatment options which may reduce the risk of transmitting HIV to the unborn child;
* Information will be provided on how to keep from transmitting HIV infection;
* My name will be reported to the Health Department for tests that indicate HIV infection. This includes, but is not limited to: HIV Antibody (Western blot), HIV Viral Load (RNA or DNA quantification), HIV viral sequencing or HIV p24 antigen tests;
* My name will be reported to the health department if my doctor finds that I have AIDS;
* I will be offered assistance in notifying and referring my partners for services. If I refuse to notify my partners, a doctor may notify them or have a representative of the local health department do so. If a representative of the local health department notifies my partners, my name will not be used. Maryland law requires that when a local health department knows of my partners, it must refer them for care, support, and treatment.

***I have been given a chance to have my questions about this test answered.***

***I hereby agree to be tested for HIV infection.***

**Print name and mailing address of the individual to be tested in the boxes below:**

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**First Name Middle Initial**

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**Last Name**

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**Date of Birth - Month/day/year**

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**Mailing Address – IMPORTANT: Confidential information being mailed**

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**City State Zip**

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**Signature of Individual to be Tested Date Employee I.D. Badge #**

**(or Authorized Substitute)**

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**Signature of Counselor or Health Care Provider Date**