Athens Limestone Hospital

700 West Market Street
Athens, Alabama 35611
Phone: (256) 233-9131 Fax: (256) 233-9455

I have been informed that my blood will be tested in order to detect whether or not I have antibodies in my blood to the Human Immunodeficiency Virus HIV) which is the probable 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 is not perfect and that the test results may, in some cases, indicate that a person has 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 the virus (false negative). I also have been informed that a positive blood result does not mean that I have AIDS, and 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 alternative tests, I may ask those questions before I decide to consent to the blood test.

I understand that the results of this blood test will be released to those health care practitioners directly responsible for my care and treatment. I further understand that positive results must be reported to the State Department of Public Health according to the laws of the State of Alabama.

I understand that Athens Limestone Hospital will take precautions to protect the confidentiality of these antibody test results. There will be no disclosure to any unauthorized third party without my express written consent except where such use or disclosure is specifically required or permitted by law.

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.

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.

By signing below, I acknowledge that I have been given all of the information I desire concerning the blood test and release of results and have dad all of my questions answered.

**I acknowledge that I have given consent for the performance of a blood test to detect antibodies to the Human Immunodeficiency Virus (HIV).

_____ _____
Signature Date

**I do not consent to the performance of the HIV antibody test.

_____ _____
Signature Date

_____
Witness

_____
Print patient's name