



Inland Empire Health Plan  
**CONSENT FOR THE HIV TEST**

I am consenting to be tested to see whether I have been infected with the Human Immunodeficiency Virus (HIV), which is the probable causative agent of Acquired Immune Deficiency Syndrome (AIDS).

**THE MEANING OF THE TEST**

This test is not a test for AIDS but only for the presence of HIV. Being infected with HIV does not mean that I have AIDS or that I will have AIDS or other related illnesses. Other factors must be reviewed to determine whether I have AIDS.

Most test results are accurate, but sometimes the results are wrong or uncertain. In some cases the test results may indicate that the person is infected with HIV when the person is not (false positive). In other cases the test may fail to detect that a person is infected with HIV when the person really is (false negative). Sometimes, the test cannot tell whether or not a person is infected at all. If I have been recently infected with HIV, it may take some time before a test will show the infection. For these reasons, I may have to repeat the test.

**CONFIDENTIALITY**

California law limits the disclosure of my HIV test results. Under the law, no one but my doctor and other caregivers are told about the test results unless I give specific written consent to let other people know. In some cases, my doctors may disclose my test results to my spouse, any sexual partner(s) or needle-sharing partner(s), the county health officer, or to a health care worker who has had a substantial exposure to my blood or other potentially infectious material. All information relating to this test is kept in my medical record.

**BENEFITS AND RISKS OF THE TEST**

The test results can help me make better decisions about my health care and my personal life. The test results can help me and my doctor make decisions concerning medical treatment. If the results are positive, I know that I can infect others and I can act to prevent this. Potential risks of the test include psychological stress while awaiting the results and distress if the results are positive. Some persons have had trouble with jobs, housing, education or insurance when their test results have been made known.

**MORE INFORMATION**

I understand that before I decide to take this test I should be sure that I have had the chance to ask my doctor any questions I may have about the test, its meaning, its risks and benefits, and any alternative to the test.

By my signature below, I acknowledge that I have read and understood the information in this form, that I have been given all of the information I desire concerning the HIV test, its meaning, expected benefits, possible risks, and any alternatives to the tests, and that I have had my questions answered. Further, I acknowledge that I have given consent for the performance of a test to detect HIV.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time \_\_\_\_\_ AM/PM  
Patient/Parent/Conservator/Guardian

If signed by other than Patient, indicate relationship \*: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time \_\_\_\_\_ AM/PM

\*This consent may be signed by a person other than the patient only under the following circumstances:

1. The patient is under twelve (12) years of age or, as a result of his/her physical condition, is incompetent to consent to the HIV antibody blood test; and
2. The person who consents to the test on the patient's behalf is lawfully authorized to make health care decisions for the patient, e.g., an attorney-in-fact appointed by the patient under the Durable Power of Attorney for Health Care; the parent or guardian of a minor; an appropriately authorized conservator; or, under appropriate circumstances, the patient's closest available relative (see chapters 2 and 20); and
3. It is necessary to obtain the patient's HIV antibody test results in order to render appropriate care to the patient or to practice preventative measures. Health and Safety Code section 121020.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Member #: \_\_\_\_\_



Provider Name: \_\_\_\_\_