

MOUNTAIN VISTA WOMEN'S CARE

*Drs. Virginia Allison, Grace Cheng, Kenneth Moss, Andrew Ross
Joan Girard, N.P. & Shelbie Lopez W.H.C.M.P.*

CONSENT – HIV TESTING

I _____ hereby authorize Drs. Virginia Allison, Grace Cheng, Kenneth Moss, Andrew Ross, NP's Joan Girard and Shelbie Lopez to order blood tests to determine the presence of antibodies to the Human Immunodeficiency Virus (HIV), or of HIV antigens in my blood. I understand that infection with HIV may produce no symptoms, may be associated with mild illness or may sometimes progress to Acquired Immunodeficiency Syndrome (AIDS).

RESULTS:

I have discussed with my provider the reason for performance of these tests. I understand that false-positive and false-negatives test results can occur. That is, a positive test result may not necessarily accurately predict the presence of HIV infection, and conversely, that HIV infection can still be present even if some or all test results are negative.

RECORDING OF RESULTS:

I understand that the results of these tests, whether positive or negative, will become a permanent part of my hospital or outpatient medical record. I understand that information in my medical record can be obtained by my health insurance carrier, if I have one, by a person or entity to whom I give written permission for access to my medical record, and under certain circumstances, by subpoena or by court order. Positive test results will be reported to State Regulatory agencies as may be required by law.

INFORMED CONSENT:

I certify that I have read and fully understood the above informed consent statement, which has been preceded by an explanation by my doctor, and was understood by me. By my signature below, I acknowledge and understand the above information and give my informed consent.

Signature: _____ Date _____

Witness: _____ Date _____