

CONSENT FOR AIDS (HIV INFECTION) TESTING

I hereby voluntarily request and consent to be tested for AIDS (HIV infection) and I agree that this consent is valid for all such tests ordered for a period of 90 days. I understand that the AIDS test administered to me may not be 100% accurate and that negative or positive test results performed on one occasion may not determine conclusively whether I do or do not have the AIDS virus.

I have also been informed that the potential physical problems to me as a result of the blood test are only those related to the routine procedure of obtaining blood specimens. The minor complications may be discomfort from the needle, slight bruising, bleeding, or soreness at the site where the blood was obtained. I have been informed of the location of anonymous testing sites.

All questions that I have regarding the procedure have been satisfactorily answered.

I recognize that my lab results will be returned to UWF Student Health Services and placed in my medical record. I authorize the disclosure of those results to all clinical, record keeping, and administrative agents and employees of UWF Student Health Services having a need to know or record this information and to my healthcare provider with whom an appointment has been set for them to disclose the results to me and provide counseling when appropriate. I further understand that the information that UWF Student Health Services may require to furnish my medical insurer or other third party payers and to those other persons to whom I shall subsequently grant a general release of medication information. I also understand and agree that the law may require the test results, if positive, be sent to the Florida Department of Health and Rehabilitative Services. I further understand that if the test results must be given to the Florida Dept. of Health and Rehabilitative Services, that agency is required by law to keep such information confidential. I do not authorize the disbursement of the results of this test to any other person or entity, other than those referred to above and such State and Federal agencies or departments as may be entitled to receive such results by virtue of state or federal law or regulations.

My signature confirms that I have read this consent form, understand its contents and significance, and agree to be tested for AIDS (HIV infection). I recognize that I have the right to withdraw my consent for AIDS testing at any time prior to a test being conducted, and I agree that if I exercise this right, I will do so in writing.

Print Name

Date/Student ID#

Signature

Witness Signature

Ordering Provider (please print)

Provider Signature