Department of State Health Services
Disclosure and Consent Human Immunodeficiency Virus (HIV) Test

TO THE PATIENT: The information in this consent form is provided so that you can be better informed about the Human Immunodeficiency Virus (HIV) Test. You must sign this form to indicate that you understand and consent to the HIV test.

I understand that the test currently used by the Department of State Health Services is an antibody test, which means that it detects the presence of antibodies to HIV, not the virus itself.

- I understand that the test uses a sample of my blood, which will be taken from a vein in my arm.
- I understand that the test uses a sample of my blood, which will be taken from a prick to my finger.
- I understand that the test uses a sample of tissue from the cheek and gums, which will be taken by a special pad that I will place between my lower gum and inner cheek.

I understand that if the first test is positive, confirmatory testing in the form of a Western Blot will be needed.

If a traditional HIV antibody test was conducted using a tube of blood or a dried blood spot card, the confirmatory test will be conducted using the original sample that indicated the presence of antibodies.

If a rapid HIV test was done, an additional sample will need to be collected for confirmatory testing. Confirmatory testing can be conducted using one of the following options and will vary from one agency to another.

The three options are:

- an Orasure test that uses a sample of tissues from the cheek and gums,
- a tube of blood is drawn, or
- a dried blood spot card is completed using blood gathered from a finger stick.

I further understand that I will be considered to be infected with HIV only after a different test confirms that my blood is positive for the Human Immunodeficiency Virus (HIV).

I understand that neither of these tests diagnoses AIDS (Acquired Immunodeficiency Syndrome). I further understand that a positive result for either test does not indicate that I have AIDS at the present time or that I will develop AIDS in the future, but that I have probably been infected with HIV, which causes AIDS.

I understand that if I am told all my test results are positive, I have probably been infected with HIV, the virus that causes AIDS. I understand that knowing the test results can help me to make important decisions in my everyday life and that the information will be helpful to my health care providers. I also understand I may be referred for more extensive counseling, medical care, and other necessary referrals to help me.

I understand in addition to the knowledge that I will receive from having the test done, there are certain risks in having a test for HIV (the virus that causes AIDS) performed. A small percentage of tests may give a "false-positive" or a "false-negative" result. I understand that a "false-positive" result means that a test has incorrectly indicated I am infected with HIV when, in fact, I am not. I understand that a "false-negative" result means that a test has incorrectly indicated I am not infected with HIV when in fact, I have been. I understand a small percentage of results can be inconclusive and may require re-testing after a period of time.

I understand there is a chance that I have been exposed to HIV (the virus that causes AIDS) and my body may not have made enough antibodies which can be detected by the tests and that I may need to repeat the tests at a later date.

I have answered all the questions about my medical history and my present health condition fully and truthfully.

I have had an opportunity to ask questions about the tests including the risks and benefits of taking these tests. Any questions I have about the tests have been answered to my satisfaction.

I understand the Department of State Health Services, its employees, nor the State of Texas has warranted the accuracy of the test results.

I understand that under the laws of the State of Texas, testing of HIV (the virus that causes AIDS) is strictly confidential and disclosure can be made to physicians, nurses, or other health care personnel who have legitimate need to know the test result(s) in order to provide for his/her protection and to provide for my health and welfare. Records will be handled in a confidential fashion, and personnel handling records have been advised of the laws addressing confidentiality in Texas.

Information about the tests has been given to me in the following manner: (check one) ☐ Orally ☐ Written

This form has been explained to me. (Check one) I have read the form ☐ or the form has been read to me ☐ and I understand its meaning.

All the blanks were filled in before the form was signed by me.

SIGNATURES

SECTION I:

Client/Patient's Names: _____

Person Authorized to Consent: _____ Relationship: _____

Signature: _____ Date: _____

SECTION II: I certify that the person who has the power to consent cannot be contacted and has not previously objected to the service being requested.

Client/Patient's Name: _____

Name of person giving consent: _____ Relationship to patient (if not patient): _____

Address: _____ Date: _____

Phone number: _____

SECTION III:

Risk Reduction Specialist/Counselor's Signature: _____