Chantilly Family Practice Center
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CONSENT TO TEST FOR HIV

1. _____ have been advised by my doctor (s) / have chosen to have a blood test to detect the presence of antibodies to the Human Immunodeficiency Virus (HIV), the virus that causes AIDS (Acquired Immunodeficiency Syndrome). I understand that the blood tests for the virus, which is probable cause of AIDS, are not 100% accurate, and that these blood tests sometimes produce false negative or false positive test results. I have been informed that a positive test will necessitate further testing to confirm the results. I further understand that the presence of antibodies means that the person probably has been infected with AIDS virus, but does not necessary mean that a person will develop AIDS.
2. I have been informed about the nature of the blood test – the expected risk and benefits and I have also had questions about HIV test answered.
3. I understand that the physician will notify me the results of the HIV test in my physical presence and explain them to me.
4. I understand that my test results will be recorded in my chart at Chantilly Family Practice Center (CFPC) and the hospitals the CFPC physicians will be treating me in the event that I am hospitalized now or in the future.
5. Subject to the foregoing, the CFPC, to the best of its ability, will not disclose results of these test to others except to the extent required by law or except such disclosure is need in order to safeguard the well-being of patients and employees at CFPC or other person at risk. Virginia State law requires that the physician notifies the Virginia Department of Health if the blood test indicates that an individual has been infected with the HIV virus (Human Immunodeficiency Virus).
6. On this basis and with full understanding of my actions, I authorize CFPC, its physician and anyone authorized by them to perform the blood test for the HIV.

Patient's signature	Date
Patient's Representative	Date
Witness	CFPC Physician