

We request permission to test your blood for the presence of antibodies to the Human Immunodeficiency Virus (HIV) the virus that causes Acquired Immune Deficiency Syndrome (AIDS). In order to perform the test, a small amount of blood (approximately 2 teaspoons) will be withdrawn from one of your arms with a needle. You may experience some slight discomfort at the needle entry site and there may be some bruising. In addition, there is a very small risk of your fainting or of infection at the needle entry site. If your test results are found to be positive, or if you are otherwise diagnosed as having AIDS, you should be aware of the following Clinical Center HIV Testing Policy:

1. Your physician will notify you promptly of the HIV test results.
2. Your physician and/or the Clinical Center HIV counselor will offer you, and any current and/or ongoing sexual partner(s) (spouses are generally considered to be current or ongoing sexual partners) or needle-sharing partner(s) you identify, information on the meaning of the test results and how to prevent the spread of HIV infection.
3. Because the virus may be transmitted in several ways, it is important that you inform sexual and/or needle-sharing partner(s) that any, or all, of them may have been exposed to the HIV virus and encourages them to be tested. If you request it, staff at the Clinical Center will assist you in notifying your partner(s) and arrange counseling for them through an HIV counselor.
4. The results of all these tests and/or documentation of the diagnosis of AIDS will become part of your Clinical Center medical record and, as such, will be protected from unauthorized disclosure by the Federal Privacy Act of 1974. In general, access to your medical record will be restricted to those healthcare professionals directly involved in your care or in the conduct of ongoing biomedical research, and information is not usually released to other third parties without your permission or that of your designated representative. However, there are some particular routine uses of such information of which you should be aware.
 - a. If you are unwilling or unable to notify your partner(s), the Clinical Center is responsible for attempting to contact and inform them of their possible exposure to the virus. Reasonable attempts will be made to protect your identity including withholding your name when notifying any partner(s) of their possible exposure. Some notification or counseling of current and/or ongoing partner(s) may be carried out through arrangements with, or referral to, local public health agencies.
 - b. A summary of your care at the Clinical Center will be sent to the physician who referred you here for treatment.
 - c. The Clinical Center may report certain communicable diseases, such as HIV infection, to appropriate State and Federal government agencies.
 - i. For Clinical Center patients who are Maryland residents, the Clinical Center reports by "Patient Unique Identifier Number" (rather than by name) newly obtained HIV-positive results from its laboratory to the Maryland Department of Health and Mental Hygiene. Patient Unique Identifier Number is: last four digits of social security number, birth month, birth day, birth year, race and gender.
 - ii. For Clinical Center patients who are Maryland residents, the Clinical Center reports by name new cases of AIDS to the Maryland Department of Health and Mental Hygiene.
 - iii. For Clinical Center patients who are not Maryland residents, the Clinical Center reports HIV-positive results and/or AIDS to the patient's primary care/referring physician.

If you have any questions regarding the HIV testing or the information provided above, you are encouraged to discuss them with your physician and/or a Clinical Center HIV counselor: (301) 496-2381.

Complete Appropriate Item Below, A or B:

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| <p>A. Adult Patient's Consent: I have read the explanation about the blood testing and have been given the opportunity to discuss it and to ask questions. I hereby consent to take part in this blood testing.</p> <p>_____ Signature of Adult Patient</p> <p>_____ Date</p> <p>_____ Signature of Witness</p> <p>_____ Date</p> | <p>B. Parent's Permission for Minor Patient: I have read the explanation about the blood testing and have been given the opportunity to discuss it and to ask questions. I hereby give permission for my child to take part in this blood testing. If other than parent, specify relationship.</p> <p>_____ Signature of Parent(s)</p> <p>_____ Date</p> <p>_____ Signature of Witness</p> <p>_____ Date</p> |
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Patient Identification

Informed Consent Statement for HIV Blood Testing
NIH-2663 (5-02)
P.A. 09-25-0099
File in Section 4: Authorization