IA AMERICAN™
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HIV TESTING NOTICE AND INFORMED CONSENT FORM

Informed Consent and Agreement to HIV Testing

I understand the following information, which I have read or has been read to me:

- blood, or another body fluid or tissue sample, will be tested for Human Immunodeficiency Virus (HIV) infection;
- consent to be tested for HIV, th
- results of this test, like all medi
- if positive test results become known, an individual may experience discrimination from family or friends and at school or work.

What a NEGATIVE Result Means

- A negative test means that HIV infection has not been found at the time of the test.

What a POSITIVE Result Means

- A positive HIV test means that a person is infected with HIV and can transmit the virus by having sex, sharing needles, childbearing (from mother to child), breastfeeding, or donating organs, blood, plasma, tissue, or breast milk.
- A positive HIV test DOES NOT mean a diagnosis of AIDS -- other tests are needed.

What Will Happen if the Test Is Positive

- A copy of the Department of Health and Mental Hygiene's publication "Information for HIV Infected Persons" will be provided;
- the health department or my doctor will offer advice about services that are available;
- women who are pregnant or may become pregnant will be told of treatment options which may reduce the risk of transmitting HIV to the unborn child;
- information will be provided on how to keep from transmitting HIV infection;
- my name will be reported to the health department for tests that indicate HIV infection. This includes, but is not limited to: HIV Antibody (Western blot), HIV Viral Load (RNA or DNA quantification), HIV viral sequencing or HIV p24 antigen tests;
- my name will be reported to the health department if my doctor finds that I have AIDS;
- I will be offered assistance in notifying and referring my partners for services. If I refuse to notify my partners, a doctor may notify them or have a representative of the local Health Department do so. If a representative of the local Health Department notifies my partners, my name will not be used. Maryland law requires that when a local Health Department knows of my partners, it must refer them for care, support, and treatment.

I have been given a chance to have my questions about this test answered.

I hereby agree to be tested for HIV infection.

_____
Proposed Insured Name (Please Print)

_____ _____
Proposed Insured Signature or Authorized Substitute Date

_____ _____
Counselor or Health Care Provider Signature Date