

## Delaware Valley Institute of Fertility and Genetics

6000 Sagemore Drive  
Suite 6102  
Marlton, NJ 08053  
(phone)856-988-0072, (fax) 856-988-0056

### CONSENT FOR HIV (AIDS) TESTING

I hereby authorize Dr. \_\_\_\_\_ to order the performance of blood tests that will determine whether I have antibodies in my blood against the Human Immunodeficiency Virus (HIV), that probably causes Acquired Immune Deficiency Syndrome (AIDS). I understand that infection with HIV may produce no symptoms, or may be associated with mild illness, and that in time might express any or all symptoms of AIDS. I have been given an explanation of the test, potential uses, limitations and the meaning of its results.

This testing will be confidential as required by State law. I understand, however, that results of this blood test will be accessible to health care personnel responsible for my care and treatment. I further understand that the test results will become a permanent part of my medical record. Moreover, I understand that my health insurance carrier may be able to obtain information from my medical records, including HIV information, to the extent necessary to make payment of a claim submitted pursuant to my policy. Further release of the test results maintained by the Delaware Valley Institute of Fertility and Genetics will not be made without my written consent or as otherwise allowed by the New Jersey Confidentiality of HIV-Related Information Act.

I acknowledge that I have had an opportunity to ask questions regarding this test and have been given the opportunity to receive pretest counseling regarding measures for the prevention of, exposure to and transmission of HIV, and that I have been given all of the information I desire concerning the blood test and release of results. I understand that I will be afforded, if I so desire, post-test counseling when the test results, whether negative or positive, are revealed to me.

I hereby certify that I have read and understood the consent statement and I give my consent to the blood tests.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Witness

I have explained to the patient the nature of the above testing and the reasonable and anticipated risks to such testing.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Physician/Counselor