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HIV Antibody Testing Acknowledgement of Counseling and Consent for Voluntary AIDS Testing

Patient Name: _____

Date: _____

The American Medical Association recommends that we offer patients routine voluntary testing for antibody to the **AIDS** virus. Women at higher risk for carrying the **AIDS** virus are:

- a. Those women with a history of intravenous drug use.
- b. Those women who have sexual contact with homosexual or bisexual males.
- c. Those women who have had blood transfusions prior to March 1985.
- d. Those women not having a monogamous sexual relationship.
- e. Those women who have had sex with a partner who is at risk.
- f. Those women who **emigrate** from a country with a high rate of **AIDS**.
- g. Those women who have had artificial insemination.
- h. Those women who have been raped.

The **HIV** antibody test is not always accurate. The test may result in a false negative by failing to detect antibodies to the virus which are in the blood. This test may also result in a false positive by indicating that there are antibodies which are not really in the blood.

For our pregnant patients, we want you to know that the **AIDS** virus is freely transmitted to the fetus. Newborns infected with the **AIDS** virus usually do not survive.

We will keep your test results as part of your complete medical record, and will not release that information without your consent, unless required or authorized by law.



My signature below acknowledges that:

- a. I have read **this consent form (or it has been read to me)**, and I understand **the provisions contained herein**.
- b. All questions regarding the **HIV** antibody test have been answered **to my satisfaction**.
- c. I understand that further information and counseling is available from the Georgia Department of Human Resources.
- d. I give **Northside OB/GYN, P.C.** permission to collect one or more blood specimens (as in other blood tests) to detect whether **such blood contains Human Immunodeficiency Virus (HIV) antibodies which are associated with Acquired Immune Deficiency Syndrome (AIDS)**.
- e. I consent to the release and use of **the** test results as set forth above.
- f. If consenting on behalf of another, I confirm that I am the patient's parent, legal guardian or next of kin, and that the patient is unable to sign **this form** because: _____

_____ I request to have the **AIDS** test done at this time.

_____ I do not request to have the **AIDS** test done at this time.

 SIGNATURE

 RELATIONSHIP TO PATIENT

 DATE