NOTICE AND CONSENT FOR AIDS-RELATED BLOOD TESTING

I, _____, willingly and voluntarily consent to and authorize the Fertility Center of California (FCC) to draw my blood and test it for AIDS-related infection agents. I agree and understand that my blood will be tested but not limited to the presence of Human Immunodeficiency Virus (HIV) antibodies. I have now been told by FCC that prior to such testing; I may wish to consider counseling, at my expense, regarding the meaning of positive test results and their reporting.

This test means that you are tested for antibodies to HIV, the causative agent for AIDS and shows whether you have been exposed to the virus. Antibodies are produced by white blood cells in the body in response to an infection. In the event the test result is positive, you will be urged to contact a private physician (at your expense), County Health Department, State Department of Health Services, Local Medical Societies, or alternative test sites for appropriate counseling. FCC is required to release your name to the California Department of Health or other County Health Agencies if the test result is positive.

I have read and understood this notice and consent for AIDS-related blood testing. I also understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be valid as the original.

Client Name:	Client signature:
Client Address:	

Submit Form

Print Form

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