## POST-EXPOSURE INCIDENT

## SOURCE INDIVIDUAL CONSENT FORM

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**Patient Name** (PLEASE PRINT) **Social Security Number**

# **Informed Consent to Blood Testing**

I have been informed that an individual has been exposed to my blood or body fluids. As a result of the exposure, I have been asked to permit my blood to be tested for HIV (known to cause AIDS), HBV and HCV.

(***Check One***)

* I hereby give my consent to such testing.
* I consent to have my blood tested for HBV, but I decline to have my blood tested for HIV at this time. I understand that by choosing this option, a sample of my blood will be kept for 90 days, during which period I may change my mind and have my blood tested for HIV at that time.

**My consent is based on the understanding that**:

* 1. My test results will remain confidential and provided only to those who have a need to know in accordance with current federal, state, and local statutes.
  2. I have been provided with information concerning HIV and HBV, and understand the contents thereof.
  3. I have been given the opportunity to ask questions concerning HIV and HBV testing.
  4. I will receive a copy of all test results.

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**Signed** **Date**

**Employer’s Representative**

I certify that the above-named individual received a copy of the HIV/HBV information sheets and has had the contents thereof fully explained.

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**Date** **Employer’s Representative** (PLEASE PRINT)

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**Title**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature**

This document will be retained in the exposed employee’s medical file.