

Frumovitz, Matsunaga, Daly, Ross, Thordarson, Vogel and Klevens, M.D.s

A Medical Corporation  
OBSTETRICS, GYNECOLOGY AND INFERTILITY

WILLIAM A. FRUMOVITZ, M.D.  
JON S. MATSUNAGA, M.D.  
CORNELIA B. DALY, M.D.

SHERYL A. ROSS, M.D.  
BO H. THORDARSON, M.D.  
KLARA VOGEL, M.D.  
SARA KLEVEN, M.D.

CONSENT TO TEST FOR HIV

I HAVE BEEN INFORMED THAT MY BLOOD WILL BE TESTED FOR THE HUMAN IMMUNODEFICIENCY VIRUS (HIV), THE CAUSATIVE AGENT FOR AIDS. I HAVE HAD A CHANCE TO ASK QUESTIONS WHICH WERE ANSWERED TO MY SATISFACTION. I UNDERSTAND THAT MY ACCURACY AND RELIABILITY ARE NOT 100% CERTAIN.

**I HAVE BEEN INFORMED THAT A SAMPLE OF MY BLOOD WILL BE TAKEN FROM MY BODY AND TESTED FOR THE PRESENCE OF HIV ANTIBODIES.**

BY MY SIGNATURE BELOW, I ACKNOWLEDGE THAT I HAVE BEEN GIVEN INFORMATION CONCERNING THE BENEFITS AND RISKS, AND I EITHER CONSENT OR DECLINE TO BE TESTED FOR HIV.

PLEASE **INITIAL** YOUR CHOICE AND SIGN BELOW.

\_\_\_\_\_ I DECLINE THE HIV TEST

\_\_\_\_\_ I VOLUNTARILY CONSENT TO THE HIV TEST

\_\_\_\_\_  
PRINT NAME

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE