G-2d16 CONSENT FOR HUMAN IMMUNODEFICIENCY VIRUS (HIV)-RELATED TESTING **TO BE USED FOR MINORS (<18 YEARS OF AGE)** *Patient, or person approved to consent for patient, must sign below on dotted line.* • This completed form is to be scanned into Epic •	DATE HOSP.# NAME BIRTH DATE ADDRESS IF NOT IMPRINTED, PLEASE PRINT DATE, HOSP. #, NAME AND LOCATION

I, the patient as named above, allow the withdrawal of a blood sample for an HIV-related test. I agree that my healthcare provider has discussed the following information with me.

- Purpose of the test
- How the test will be used
- The meaning of both positive and negative results

If the test result is positive:

- The hospital will need to notify:
  - The Iowa Department of Public Health and the patient's local Public Health Agency
  - The patient's legal guardian
- I, the patient, and my legal guardian will be offered services for:
  - Family support
  - Counseling
  - Treatment

Test results will only be given:

- During a face-to-face visit

  or

- By telephone

  and

- Results will be in MyChart (the electronic medical record that is viewable by the patient and legal guardian, if electronic access has been requested)

I have received information about my treatment and risks. I have been given time to ask questions. I agree to have HIV testing during this health care visit (sign below).

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Signature of patient or person authorized to consent for patient   Date

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