**POST-EXPOSURE BLOOD/BODY FLUIDS**

**CONSENT TO SEROLOGY TESTING**

**Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. I, the undersigned, hereby authorize and consent to a series of blood tests to determine HIV and HEPATITIS B serum status.

2. I hereby acknowledge that \_\_\_\_\_\_\_\_\_ has provided information regarding the risks, benefits, effects, and alternatives to the testing. I further acknowledge that I have received all the information that I desire and have had all my questions satisfactorily answered about the testing.

3. I hereby acknowledge that post testing counseling will also be available to me at no cost.

4. I hereby acknowledge that the testing is offered to me at no cost and no coercion from the hospital and that I have chosen voluntarily to participate in the series of tests. I realize that I am free to withdraw this consent at any time and discontinue testing.

**Signed:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Dated:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Witnessed:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Time:**