OBGYN
Specialists of Columbus

Ruthann F. Rees, M.D., Ph.D., FACOG

# *HIV (AIDS) ANTIBODY SCREEN CONSENT FORM*

***PATIENT:***
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***ADDRESS:***
_____

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***TELEPHONE:*** _____

***ORDERING PHYSICIAN:***
Ruthann F. Rees, M.D., Ph.D.

2000 Tenth Avenue, Suite 380

Columbus, GA 31901

***TELEPHONE:*** (706) 324-0471

My health care provider named above has requested I submit to an HIV (AIDS) Antibody Test. I understand that antiviral drugs taken by the mother can greatly reduce the risk transmittal of HIV to the baby. I understand that I have the opportunity to refuse this test. I acknowledge that I have received pre-test counseling about the HIV (AIDS) Antibody test and I understand that the results of this test will become part of my medical record, and the results will be communicated to my health care provider named above.

I hereby authorize testing of my blood for the HIV (AIDS) Antibody and I further agree that I will be present myself for counseling should the test be positive.

Signature of Patient/Authorized Representative _____ Date _____

Witness _____ Date _____