



CONSENT FOR HIV TESTING AND DISCLOSURE OF RESULTS

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FIELD SERVICES

SFN 1154 (3-2025)

| | | |
|-------------|----------------|---------------|
| Client Name | Client ID | Date of Birth |
| Episode | Admission Date | Current Date |

| | |
|---|------|
| I consent for HIV testing and disclosure of positive results. <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| <ol style="list-style-type: none">1. This blood screening test detects the presence of HIV antibodies.2. The blood is sent to an outside reference lab for testing.3. I understand the procedure and possible risks.4. North Dakota State Hospital may disclose positive results to the following:<ol style="list-style-type: none">a. Meb. Healthcare provider and his/her agent or employeec. Blood bank, blood center, or plasma centerd. A Healthcare provider who procures, processes, distributes, or uses a human body part lawfully donated by mee. State health officer or designee for the purpose of epidemiologic surveillance or control of communicable diseasef. Licensed embalmerg. Accreditation body or healthcare services review organization for the purpose of program monitoring and evaluation | |
| Signature of Client or Legal Representative | Date |