# MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Number, and Edition Date.

| REQUIRING DOCUMENT *(Title and Number)* | ISSUANCE DATE |
|---|---|
| | |

**LOCAL FORM TITLE *(Optional)***

1. By my signature below I consent to have an HIV test. This test detects whether or not my body is making antibodies to the Human Immunodeficiency Virus, the virus that causes Acquired Immune Deficiency Syndrome (AIDS). The results of this test will tell whether I have or have not been infected with HIV. I understand that it can take up to six months from the time of exposure to the HIV virus for my body to produce the antibodies that would make my HIV test positive. I also understand that I may need to consent to further testing in three to six months.

2. I understand that a positive HIV blood antibody test can have a negative impact on my personal relationships, my job, my health and/or my life insurance. I should arrange an appointment with my doctor for a later date in order to be counseled about the results and meaning of my HIV blood antibody test. The results will be documented in my health record at that time. If my test is positive, I understand it is my responsibility to tell my sex partner(s) and anybody with whom I may share or have shared needles with that I am HIV infected. If I do not want to tell my sex or needle sharing partners, I understand that the Department of Defense may be obligated to tell them as indicated in applicable laws and regulations.

3. I understand that the results of this blood test will only be released to those health care practitioners directly responsible for my care and treatment. I further understand that no additional release of the results will be made without my written authorization. By my signature below I acknowledge that I have been given all the information I desire concerning the blood test and have had all my questions answered to my satisfaction.

Date: _____ Signature: _____

Witness: _____

| PRACTITIONER'S NAME | PRACTITIONER'S SIGNATURE | DATE |
|---|---|---|
| PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)* | HOSPITAL OR MEDICAL FACILITY | STATUS |
| | DEPARTMENT / SERVICE | RECORDS MAINTAINED AT |
| | SPONSOR'S NAME | SSN |
| | RELATIONSHIP TO SPONSOR | |