Exposed Patient Consent for Testing for Occupational Exposure to Blood or Body Fluids

Name (print): _____ Chart ID/MRN: _____

I have read and understand this document and hereby consent to be tested by Olmsted Medical Center (OMC) through a blood serum test for the following (check all that apply).

☐ ANTI HBs (Hepatitis B Virus Antibody)
☐ ANTI HIV/AIDS (Human Immunodeficiency Virus)
☐ ANTI HCV (Hepatitis C)

I understand that this information and the test results will be kept confidential and will not be released without my consent to anyone who does not have a legal right of access to the information. This information will not be released to an insurance company without my consent. I understand I will receive a copy of the test results. I further understand that OMC will comply with Minnesota health codes pertaining to the reporting of communicable diseases, and that a copy of all test results will be maintained by OMC unless otherwise specified.

I understand that my Hepatitis B vaccination status will be released to my employer.

I understand that blood serum testing will be done without identifying me to anyone outside OMC.

I understand that the costs resulting from this testing procedure and for Hepatitis B vaccination, if needed, and any follow-up testing deemed necessary and/or appropriate and consistent with common accepted medical practice will be paid by my employer.

Test results will be maintained by OMC and will be reported to the Minnesota Department of Health, as required, if the test results are positive.

Name of Patient (Printed)	Patient/Parent/Legal Guardian Signature	Date/Time
Name of Staff Witness (Printed)	Staff Signature	Date/Time
Name of Interpreter (Printed) (if used)	Interpreter Signature	Date/Time

Declination of Testing

I have read and understand this document. I have chosen not to have my blood tested at this time. However, I hereby consent to have samples of my blood serum drawn and held by OMC for future testing, with my consent, for the following:

☐ ANTI HIV/AIDS (Human Immunodeficiency Virus Antibody)

I understand that the samples will be preserved for at least 90 days from the date of exposure and that I may request testing for the HIV antibody anytime during this 90-day period. I understand that this testing will only be done with my consent. If I do not consent to testing within 90 days, the blood samples will be destroyed.

Name of Patient (Printed)	Patient/Parent/Legal Guardian Signature	Date/Time
Name of Staff Witness (Printed)	Staff Signature	Date/Time
Name of Interpreter (Printed) (if used)	Interpreter Signature	Date/Time