The Baltimore Life Insurance Company
10075 Red Run Boulevard Owings Mills, Maryland 21117-4871

CONSENT FORM FOR THE HUMAN IMMUNODEFICIENCY VIRUS (HIV) TEST

I have been informed that my blood or oral sample from my mouth *or my urine* will be tested for the Human Immunodeficiency Virus (HIV), the virus that causes AIDS.

I acknowledge that I have been given an explanation of the test, including its uses, benefits, limitations, and the meaning of test results.

I have been informed that the HIV test results are confidential and shall not be released without my written permission, except to _____* and as permitted under state law.

I understand that I have a right to have this test be done without the use of my name. If my private physician does not provide anonymous testing, I understand I may obtain anonymous testing at a Michigan Community Public Health Agency-approved HIV counseling and testing site.

I understand that I have the right to withdraw my consent for the test at any time before the test is complete.

I acknowledge that I have been given a copy of the booklet *Important Health Information*. I have been given the opportunity to ask questions concerning the test for HIV, and I acknowledge that my questions have been answered to my satisfaction.

By my signature below, I consent to be tested for HIV.

_____ _____
Patient/Parent/Guardian Signature Date

_____ _____
Witness Date

AT THIS TIME, I DO NOT WANT TO BE TESTED FOR THE HUMAN IMMUNO-DEFICIENCY VIRUS

_____ _____
Patient/Parent/Guardian Signature Date

_____ _____
Witness Date

*** Please write in the physician and/or health facility name who will receive the HIV test results.**

Attach White Copy to the Application
Give Yellow Copy to the Applicant

Form 7222(MI)