HIV/STI COUNSELING, TESTING, REFERRAL AND TREATMENT SERVICES
INFORMED CONSENT AND REQUEST FOR ACCESS TO PATIENT PORTAL
(Individuals 18 and Over)

The self-identifying and contact information requested below is needed so that we can contact you if follow-up care and treatment is necessary**. IT IS VERY IMPORTANT THAT YOU PROVIDE ACCURATE INFORMATION.**

INFORMED CONSENT

I voluntarily agree to receive HIV/STI counseling, testing, referral and treatment services from WWH and authorize the staff and volunteers of WWH to provide such care or treatment as necessary and advisable for me. I understand that I should participate in planning for my care and have a right to refuse interventions, treatment, care, services or medications *at any time,* to the extent the law allows.
I know that the care I will receive may include tests, injections and medications which are of minimal risk and based on established medical criteria. I have been informed that if I am tested for HIV and my initial Rapid Test result is reactive (preliminary positive), a Multispot and/or a PCR test may be performed for confirmation of my status and the test results will be on my record. I understand that WWH will offer to help me with any medical treatment or emotional support that I may need based on my test results.

I know that WWH sometimes has students/residents being trained as doctors, nurses, therapists and other health care providers who might be helping to care for me. These students are under the supervision of licensed providers. Finally, I understand that some services may require me to sign another Informed Consent to Treatment.

NOTICE OF PRIVACY PRACTICES

WWH considers my protected health information to be confidential, and will not share it with anyone outside of WWH without my consent unless permitted or required by law. I have been informed, for example, that if I am diagnosed with HIV or any sexually transmitted disease, my name and other information about me will be reported to the public health authorities as required by law.
I have been given a copy of WWH's Notice of Privacy Practices, have had the chance to ask questions about the Notice, and feel comfortable with the protections that it offers me.

HEALTH INFORMATION EXCHANGE

I am aware that WWH participates in certain health information exchanges with other hospitals and health centers located in the metropolitan area, including the Chesapeake Regional Information System for our Patients (CRISP) and the Capital Partners in Care Health Information Exchange (CPC-HIE). I understand that my health information will be shared with these exchanges. My understanding is that information about me is being shared with providers and public health officials outside of the health center for treatment purposes, in order to better coordinate my care, and to assist providers and public health officials in making more informed decisions. I have been informed that I have the right to "opt-out" of health information exchanges at any time by requesting, completing and submitting a copy of WWH's "opt-out" form.

ELECTRONIC COMMUNICATIONS

I understand that WWH may need to communicate with me via e-mail or SMS/text messaging regarding aspects of my medical care, including test results. I know that unencrypted electronic communications are not confidential and may be intercepted by third parties or transmitted to unintended parties. I am consenting to unencrypted electronic communications when necessary with the understanding that WWH will, to the best of its ability, limit the information about me that it includes in any electronic communication.

By signing my name below, I am acknowledging that I have read, and fully understand, each of the separate paragraphs set forth above. I have had a chance to ask WWH staff or volunteer any questions I may have. This consent lasts for as long as the treatment continues, unless I exercise my right to withdraw my consent at any time.

Print Full Name: ____

Date of Birth: ____

Address: ____

City: _________________ State: ____________________ Zip Code: ________________

Phone Number: Home: ______________ Work: _________________ Cell: ______________

Signature: _______________________________ Date: ________________________

Relationship to Patient (If not patient, *e.g.*, guardian or personal representative) ____________

OPTIONAL REQUEST TO ACCESS PATIENT PORTAL FOR STD TESTING

I would like to be registered for access to WWH's Patient Portal so that I can access my test results. I understand that I must present proof of identity prior to accessing the WWH Patient Portal and that it is very important for me to provide an accurate e-mail address (and to notify WWH of any change in my e-mail address) so that I can access my test results and other information that may be contained in my electronic medical record via the Patient Portal.

Signature: ____

E-Mail Address: ____