WHITMAN-WALKER HEALTH

Informed Consent for HIV/STI Testing - Minors

You have the right as a patient to be informed about any recommended surgical, medical, or diagnostic procedure to be used in the course of your care so that you may make the decision whether or not to undergo the procedure after knowing the risks involved. If you have any questions about any of this information or need help completing this form, please do not hesitate to ask a member of our staff. It is important to us that you feel comfortable with all of this information. By signing, you are indicating that you understand the information, have been given a chance to ask questions, and are giving your consent for yourself (if 13 years old or older), or your child/minor for whom you have legal responsibility.

The purpose for undergoing testing for HIV and other Sexually Transmitted Infections (STIs) is to diagnose any conditions you might have so that you can receive appropriate treatment. HIV and STI testing will involve: a blood draw, urine sample as well as swabs of any rashes and swabs of the throat, rectum, and vagina. It may also include a genital exam.

You understand that the physical risk of undergoing testing for HIV and other STIs is minimal, but may include a genital exam, blood draw and swabs of affected areas. Side effects from these exams may rarely lead to bruising, dizziness, or soreness.

By signing below you acknowledge that WWH considers your protected health information (PHI), including your test results, to be confidential and will not share it with anyone outside of WWH without your consent unless permitted or required by law or any ethical requirements that may be applicable. You understand, for example, that if you are a minor patient, test positive for an STI, and refuse to seek treatment, WWH is required by the District of Columbia to inform your parent(s) or guardian(s) (if known) about any treatment needed for the diagnosed STI. You also understand and acknowledge that WWH is permitted to disclose information about you in order to bill for services provided to you.

By signing my name below, I acknowledge that I have read, and fully understand, each of the separate paragraphs set forth above, and attest that I am a minor age 13 or above or the parent/guardian of a minor age 13 or above.

Printed Name of Patient:	**Date of Birth:**
Signature: *(If applicable)*	**Date:**
Printed Name of Parent/Legal Guardian:	
Relationship to Patient:	
Signature:	**Date:**