**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_HEALTH DEPARTMENT**

**PATIENT CONSENT FORM\***

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, as a patient of the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Health Department, agree to have blood drawn to test my blood for serological evidence of infectious diseases including but not limited to, Hepatitis B and the Human Immunodeficiency Virus (HIV) because an employee of the Health Department has had an unintentional exposure to my blood or other potentially infectious material. The potential physical problems to me are those related to the routine procedure of taking a blood sample. My signature confirms that I have read this consent form; have received an explanation and understand the reasons for the tests, and agree to have these tests done.

Patient/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

**Person authorized to sign for**

Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
  
Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have read the above information and understand why I have been asked to give consent for these tests, but I do not give consent at this time, even though my physician has ordered it.

**Patient/Guardian**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_

**Person authorized to sign for**

Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
  
Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*NOTE: **The** [**CH-5 Form**](https://chfs.ky.gov/agencies/dph/dafm/Pages/lhd-documents.aspx) **is the form for use in obtaining a Patient General Consent for Public Health Services**. *ONLY use this form when patient has not signed a CH-5, General Consent Form.*