OAKLAND UNIVERSITY

Authorization to Have Blood Drawn and Analyzed for Presence of Viral Infection Source Individual Consent Form

1. Individual's Name ____

   Date of Birth ____

2. I authorize ________________________ (Name of Health Care Facility to draw and analyze my blood for the presence of viral (i.e., HBV or HIV) infection.

3. I understand that the results of this analysis shall be made available to the individual who has been exposed to my blood (in addition to his/her health care provider) and maintained in that individual's CONFIDENTIAL medical records on file at OU.

4. I agree that a photocopy or facsimile of this authorization shall be valid as the original.

____ ____________________

Signed (source individual) Date

____ ____________________

Parent or guardian (if individual is under 18 years of age) Date