Request for Testing of Source Patient

Patient Authorization

It has been determined that another person has had a significant exposure to your blood or body fluids. In order to make appropriate medical decisions for this person, we are requesting that your blood be tested for the following bloodborne pathogens:

- Hepatitis B
- Hepatitis C
- Human Immunodeficiency Virus (HIV)
- Syphilis (RPR)

This testing will be provided free of charge and your healthcare provider will be provided the results.

Your cooperation is greatly appreciated.

I authorize UCR Health to test my blood for evidence of the above mentioned bloodborne pathogens, and my authorization to release the results to the following provider for the purpose of evaluating the potential exposure to another.

☐ I choose not to be informed of the blood test results

☐ I decline pre-test counseling ☐ I decline post-test counseling

Name of Provider to Receive Test Results: ___________________________________

Address of Provider: ____

Patient Name (printed): ____

Patient Signature: _____________________________________Date: _____________

Name of Witness (printed): ____

Witness signature: ____________________________________Date: ______________