# Consent Form for the Release of Medical Results

*Please print the following information:*

| | | | |
|---|---|---|---|
| Last Name | First name | MI | |
| Street Address | City | State | Zip |
| SS# | Date of Birth: | Home Phone | |
| Affiliation (if any): | | | |

**Purpose:**

The OSHA bloodborne pathogens standard; 29CFR1910.1030; requires the employer to identify the source individual of blood or other potentially infectious material which resulted in an exposure incident to a Towson University employee.

To assist in the evaluation of potential exposure of bloodborne pathogens to the Towson University employee, the University is requesting that the above source individual submit to voluntary blood collection and testing. Towson University agrees to incur the cost for collection and analysis of the source individual's blood.

By signing this form, the source individual agrees to sign all appropriate documents to authorize the results of the tests to be released to the exposed employee by the medical facility providing this service.

**Agreement:**

I hereby authorize (fill in Medical Facility): _____ to collect blood for the purpose of performing laboratory tests to determine my medical status related to human immunodeficiency virus (HIV), hepatitis B (HBV) and hepatitis C (HCV), and I agree to sign the necessary documents used by the Medical Facility to authorize such testing and release of information.

I understand these services are performed by (fill in Medical Facility): _____ at the request of Towson University. I further understand the results will be used solely to determine if a potential exposure to bloodborne pathogens may have occurred. I further understand that the results of this test will be communicate to the above named facility, the exposed Towson University employee and other individuals as authorized by law through verbal and/or written reports.

I have read and understand this form and voluntarily agree to the terms and conditions.

**Your Signature:** _____ **Date:** _____

**Witness Signature:** _____ **Date:** _____