



Midwifery Care Associates, P.C.
2 Tree Farm Road • Suite A110 • Pennington, NJ 08534 • 609.737.7512

HIV CONSENT

NAME _____

In accordance with P.L. 2007, c.218 ('Codey Law)

I acknowledge that the midwives of Midwifery Care Associates have counseled and provided me with:

- A. Information concerning how HIV is transmitted
- B. The benefits of voluntary testing.
- C. The benefits of knowing if I have the HIV virus or not,
- D. The treatments which are available to me and my unborn child should I test positive, and
- E. That I have a right to refuse the test and I will not be denied treatment

First Trimester:

I have consented to be tested for infection with HIV. _____

I have decided to opt-out of testing for infection with HIV. _____

Third Trimester:

I have consented to be tested for infection with HIV. _____

I have decided to opt-out of testing for infection with HIV. _____

Labor: (if not done in third trimester)

I have consented to be tested for infection with HIV. _____

I have decided to opt-out of testing for infection with HIV. _____