



INFECTIOUS DISEASE SCREENING WAIVER

(Print Partner's full name)

My physician has advised me that I should get this testing done. In spite of my doctor recommending the tests, by initialing below I choose not to get this test done. I wish to proceed with infertility treatment.

Initial

Initial

HEPATITIS CORE AB

HIV

HEPATITIS C

RPR

HEPATITIS B SURFACE AG

TYPE AND SCREEN

_____ I agree to the above tests and the options I have indicated.

_____ I decline the above tests and the options I have indicated.

Partner Signature

Date

Physician Signature

Date

Witness Signature

Date