**Informed Consent for HIV Partner Services**

1. I understand that participation in partner services is a voluntary choice. I have been counseled on partner services and agree to ensure that my partners, family members and/or other contacts are provided with counseling and testing for HIV.
2. The trained provider has informed me about benefits of HIV testing and early enrollment into treatment
3. The trained provider has provided me with options for partner services
4. Discomforts associated with notifying my partner may occur and assistance and support may be available from my healthcare provider.
5. My name and means of exposure will be kept confidential and not be disclosed to my partner(s), unless you specifically request, when contacted by a healthcare professional.
6. I agree with the shared confidentiality, indicating that only healthcare providers and professionals directly involved in your care will have access to your health records.
7. In case of pertinent questions I may contact your healthcare provider for further clarification.
8. The trained provider has informed me that whether I agree or disagree with Partner Notification services, I still receive treatment at my current health facility.
9. Based on my discussion with my healthcare provider and the information that I have received, I give my consent to the process of Partner Notification.

Patient (Index) Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Counselor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_