INFECTION CONTROL

If any employee of Oral and Maxillofacial Surgery Associates, P.C. or other healthcare worker is exposed to my blood or other body fluids, I hereby authorize Oral and Maxillofacial Surgery Associates, P.C. to test my blood for Hepatitis B and HIV (the virus that causes AIDS). I understand the tests will be done at the expense of Oral and Maxillofacial Surgery Associates, P.C.

Signed: _____ Date: _____