



TATA MEDICAL CENTER, KOLKATA

CONSENT FORM FOR ANTI-HBs TESTING IN BLOOD DONORS

Name of Donor: _____

Age/Sex: _____

Donor ID / Registration No.: _____

Date: _____

- I have been informed that my blood sample will be tested for **anti-HBs (antibody to Hepatitis B surface antigen)**. This test helps determine my immunity status against **Hepatitis B**.
- I have had the opportunity to ask questions, and my questions have been answered satisfactorily.
- I understand that my test results will be kept confidential and used only for medical purposes and results may be shared with me.
- I understand that I have the right to refuse or withdraw consent at any time before testing without affecting my eligibility for standard care.

Declaration

I hereby give my informed consent for anti-HBs testing.

Signature / Thumb Impression of Donor: _____

Name & Signature of Counselor/Medical Officer: _____

Contact Information: _____