

Please carefully read the following and sign below:

A. PERMISSION FOR TREATMENT AND UNDERSTANDING OF DEEMED CONSENT

I understand that the information in my health record is confidential and for the use of the attending staff. I give permission to Richard Bland College, Health & Wellness Clinic (H&WC) to provide diagnostic, therapeutic, voluntary immunization, and operative procedures and emergency transportation as deemed necessary by the medical staff on my behalf. I understand that my health information will be used as necessary to coordinate and manage my health care which may, when appropriate, include auxiliary staff such as Southside Regional Medical Center physicians, student Nurse Practitioners, Nurses, LPNs, CNAs, PA's, and RBC personal counselors.

B. DEEMED CONSENT FOR HIV TESTING (VIRGINIA STATE LAW) 32.1-45.1

Whenever any health care provider, or any person employed by or under the direction and control of a health care provider, is directly exposed to body fluids of a patient in a manner which may, according to the then current guidelines of the Centers for Disease Control, transmit human immunodeficiency virus (HIV), the patient whose body fluids were involved in the exposure shall be deemed to have consented to testing for infection with human immunodeficiency virus (HIV).

C. REPORTING COMMUNICABLE DISEASES

Should you be diagnosed with a disease, toxic effect or condition that is listed on the Virginia Reportable Disease List, by the Virginia Department of Health, the Physicians and Nurse Practitioners in H&WC are directed by the Statutes of Virginia to report this condition without your consent. In addition, VA law will require you to give the health department all names of contacts.

D. AUTHORIZATION OF PAYMENT

I understand that I am responsible for all fees associated with my care and treatment in H&WC and that those fees are payable at the time of service. I will be responsible for any legal and / or collection fees resulting from nonpayment. I give permission to H&WC to release information upon request regarding claim for the noted charges, to my insurance company, to facilitate payment of insurance claims.

I have been informed of and understand the above statements regarding permission for treatment, deemed consent and authorization of payment. I am eighteen (18) years of age or older.

PATIENT'S SIGNATURE _____ **Date:** ____/____/____

(No treatment will be given if not signed.)

Or, if a Minor

Parent/Guardian Signature _____ **Date:** ____/____/____

(This consent is effective from the date of signature until the minor turns 18 years of age).

Consent to Release Medical Information

Your Right to Medical Information Confidentiality

HIPAA is an acronym that stands for Health Insurance Portability and Accountability Act that was made into law in 1996. By law, if you are 18 years or older, you have the right to strict confidentiality regarding your visits to H&WC. In order to release any information, including the date or nature of your visit to anyone not already listed in paragraph A above, H&WC has to have your signed consent and specific directions about what information you are consenting to be released. Without written consent, H&WC cannot release or discuss any information relating to your visit with anyone including your parents, guardians, spouse, faculty, staff, coach, and other medical professionals.** In addition you have the right to revoke this authorization at any time, and will be effective when H&WC receives a written copy of your revocation. A copy of this authorization will be kept in your H&WC health record.** The information disclosed under this authorization might be re-disclosed by a recipient and may, as a result of this disclosure, no longer be protected to the same extent as this information was protected by law while solely in the possession of H&WC.

I understand the above statement and give consent to H&WC to discuss the following information regarding my health and/or visit to H&WC with:

Parent: _____ Guardian: _____

Other: _____

Signature: _____ **Date:** ____/____/____

This consent will expire on: ____/____/____