MEDICAL ASSOCIATES OF SOUTHWEST VIRGINIA

Authorization to Release Information:

May we leave messages regarding future appointments on your voice mail or email? **Yes** **No**

May we leave biopsy or test results on a voice mail? **Yes** **No**

I authorize Medical Associates of Southwest Virginia to discuss my care and/or appointments with the following person(s).

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Consent for HIV, Hepatitis B or C testing:

_____ Medical Associates is required by section 32.1-45.1 of The code of Virginia, as amended, to give you notice that if any Medical Associates healthcare provider, worker or employee should be directly exposed to your blood or bodily fluids in any way that may transmit disease, your blood will be required to be tested for infection with the human immunodeficiency virus (AIDS virus) as well as Hepatitis B and C. A physician or other healthcare provider will notify you of the results of the test. Under VA code section 32.1-45.1A, you are deemed to have consented to the release of the results to the person exposed. Medical Associates will only be responsible for any expenses incurred for this testing under the circumstances listed above.

Lifetime Signature Authorization for Medicare Patients and Release Authorization for Private Insurance and/or Physician Referrals:

_____ I request that payment of authorized Medicare benefits and any other carrier be made on my behalf to Medical Associates of Southwest VA Inc for any services furnished me by the physician. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and any other carrier and its agents any information needed to determine these benefits payable for related services.

Release of Personal Health Information (PHI) or Related Data:

_____ I hereby authorize Medical Associates of Southwest VA Inc to release to or release from any physician, his/her office, or any other medical facility information necessary for referral purposes. This authorization shall remain in force until written notice is given from the patient or responsible person.

General Consent for Treatment:

_____ I hereby authorized the physicians of Medical Associates of Southwest Virginia Inc his/her staff to perform and do hereby consent to such medical treatment as he/she feels is necessary, diagnostic procedures, medical examinations and treatment as may, in his/her opinion be medically necessary. I am aware that the practice of medicine is not an exact science and I acknowledge than no guarantees have been made to me as to the result of any procedure, treatment or examination.

I have read and initialed my understanding of the above policies and authorizations. I have had the opportunity to review the Privacy Practices for Medical Associates and consent to be bound by those policies.

SIGNED_____ DATE _____/_____/_____