Pediatric Partners of Virginia Consent for Treatment

I understand, that the laws of Virginia require that if my physician or any person employed by my physician(s) is directly exposed to my bodily fluids that may transmit the Human Immunodeficiency Virus (HIV) or Hepatitis B or C viruses according to the current guidelines for the Center of Disease Control (CDC), that I consent to be tested for infection with HIV or Hepatitis B or C viruses. I further understand that by law I consent to the release of these test results to the person(s) who are exposed to my bodily fluids.

Signature of Patient _____ Printed Name _____ Date _____

OPTIONAL: DISCLOSURES TO FAMILY / FRIENDS (not including daycare, schools, camps)

Please list all persons (Parent, Grandparent, Friend, etc.) who may receive my (18+) health information regarding but not limited to scheduling, medical advice, treatment, prescriptions, medical forms, medical records and billing information. These individuals may be asked to present identification. If someone other than those you list below contacts us regarding your medical care, we will contact you for permission to advise or treat. In the event of an emergency, we will treat and make every possible attempt to contact you.

NAME	RELATIONSHIP	PHONE Number	Restrictions (if any)

This authorization will remain in effect until further written notice by patient/legal representative to discontinue. I understand that once information is released the information may be subject to redisclosure by the party receiving the information and may no longer be protected by federal or state law.

Signature of Patient _____ Printed Name _____ Date _____

THIS ACKNOWLEDGEMENT WILL BE SCANNED INTO THE PATIENT'S PERMANENT ELECTRONIC MEDICAL RECORD.