DOMINION
INTERNAL MEDICINE

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PATIENT CONSENT

This authorization permits Dominion Internal Medicine to release the specified protected health information to the following person(s) upon request: **(example: self, spouse, adult child, other physician, etc.) Please include Name, Address and/or Phone Number:**

_____ _____

_____ _____

Please initial the appropriate section of your protected health information that you are authorizing to release:

_____Entire Medical Record _____Lab/Test/Xray Results _____Most Recent Office Note

_____Demographic Information _____Other: (Specify :) _____ _____Declined

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to the practice's Privacy Officer at 225 Oak Springs Drive, Suite 201, Warrenton Virginia, 20186. Revocations are not effective until received by the Privacy Officer. The revocation must include the patient's account number, name, address, the date of the original authorization, the recipients of the original authorization, the date of the revocation and the patient's signature. Dominion Internal Medicine will accept written revocations of this authorization via: U.S. mail, in person, or by fax.

I authorize Dominion Internal Medicine and/or their administrative/clinical staff to use or disclose my protected health information within the measures listed above. This authorization shall expire two years from the date of signature.

_____ _____

Patient/Guarantor Signature Date

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I understand and have been provided with a ***HIPPA Privacy Notice*** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

As part of my health care treatment, I understand the office may try to contact me by phone. Please initial the following:

- It ☐ is/ is not ☐ acceptable to leave a message regarding my protected health information including test(s) results on my answering machine.
- It ☐ is/ is not ☐ acceptable to leave a message regarding my protected health information including test(s) results with a member of my household.
- It ☐ is/ is not ☐ acceptable to discuss my protected health information with the emergency contact person that I have listed in the event that the office cannot reach me at the home/work number(s) that I have provided.
- It ☐ is/ is not ☐ acceptable for a member of my household to pick up my written prescription.

I fully understand and accept / decline the terms of this consent.

_____ _____

Patient/Guarantor Signature Date