



Patient Consent and Release of Information

I understand and have been provided with a HIPAA 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.

I authorize, Dominion Internal Medicine, to release my protected health information to the person(s) listed below over the phone, in person or via mail. This authorization shall expire two years from the date of signature.

- Self: Phone:
Spouse/Significant Other: Phone:
Adult Child: Phone:
Primary Care Physician: Phone:
Specialist: Phone:
Other: Phone:
No release of medical information at this time

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.

Patient Contact

- As part of my health care treatment, I understand the office may try to contact me by phone. Please check the following:
Yes No It is acceptable to leave a message regarding my protected health information including test(s) results on my voicemail.
Yes No It is acceptable to leave a message regarding my protected health information including test(s) results with a member of my household.
Yes No It is 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.
Yes No It is acceptable for a member of my household to pick up my written prescription.
Yes No It is acceptable to communicate via text, email or through the patient portal where applicable.

Advance Directive, Living Will, Do Not Resuscitate

Our physicians and medical providers honor our patients' end-of-life wishes, including Advance Directives, Living Wills and resuscitation desires. Please check the appropriate section if you have any of the following documents.

Advance Directive Living Will Do Not Resuscitate (DNR) Not applicable

Prescription Eligibility Acknowledgment

I am aware Dominion Internal Medicine and it's affiliated Providers will be obtaining prescription eligibility information at each office visit. This will provide basic prescription benefits and history information from my insurance (if applicable) for prescribing purposes.

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

Patient/Guarantor Signature Date