

**Deemed Consent for Designated Blood-Borne Pathogens,
Consent to Medical Care, and Release of Information and
Protected Health Information**

Please read the following information and sign at the bottom:

Virginia law requires health care providers to notify you that Hepatitis B and C and human immunodeficiency virus (HIV) testing on a sample of your blood may be done if a health care worker is exposed to your blood or body fluids. This following notice is to advise you that this policy is in effect at this facility.

Under the Code of Virginia, Section 32.1 – 45.1, whenever any health care worker associated with or working for **FOX AND BRANTLEY INTERNAL MEDICINE** is directly exposed to body fluids of a patient in a manner which, according to the guidelines of the Center for Disease Control, may transmit HIV or Hepatitis B and C, **FOX AND BRANTLEY INTERNAL MEDICINE** will proceed to test the patient through his or her physician and to test the health care worker(s) who was/were exposed. When a person is exposed, we automatically test for HIV, Hepatitis B and C for the safety of all concerned. If your insurance company requires a referral for this testing, you are responsible for obtaining the referral. If the referral is not obtained you may be held responsible for payment in full by the specialist for the date of service.

I voluntarily consent to medical care by **FOX AND BRANTLEY INTERNAL MEDICINE**, which may include examinations, tests, photographs, and treatments by doctors and the staff. No promises have been or will be made to me as to the results of treatment or examinations.

I hereby authorize the release of any medical information required to process my insurance claim. I also authorize my insurance benefits to be paid directly to the physician and understand that I am financially responsible for all services provided.

I acknowledge that I have received or have been offered a copy of **FOX AND BRANTLEY INTERNAL MEDICINE** Notice of Privacy Practices.

Name (print) : _____

Signature: _____ Date: _____

Relationship to patient: Patient Spouse Parent Child Sibling Other _____

Please indicate here if patient is unavailable to sign or acknowledge consent: _____