Salem Surgical Associates (SSA)

Patient Name: ____ DOB: _____________

1. **Notice of Deemed Consent to HIV Blood Testing**. Should an employee be exposed to my blood/bodily fluid in a way that might allow transmission of infection due to blood borne disease (i.e. HIV, Hepatitis B, etc.) or other communicable diseases, then I understand that samples of my blood or bodily fluid may be tested for evidence of infection according to Virginia state Law.

2. **Release of Medical Information or Related Data:** I hereby authorize SSA to release from any physician, his/her office, or any other medical facility information necessary for referral/coordination of care purposes. This authorization shall remain in force until written notice is given from me or any other designated person.

3. SSA will maintain patient records for a minimum of seven years following the last patient encounter. Records of a minor child shall be maintained until the child reaches 18 years of age, or becomes emancipated, with a minimum time for record retention of six years from the last patient encounter regardless of the age of the child.

4. **Authorization to Release PHI for participation in Electronic Prescription Database:** I authorize the use or disclosure of my individual Protected Health Information (PHI) as described below with the understanding that this authorization is voluntary and may be revoked at any time by notifying SSA, in writing, except to the extent it has already taken action in reliance of this Authorization. This authorization covers individual prescription (present and future) PHI and prescription history disclosed by physicians and other employees of Salem Surgical Associates as well as to employees and agents of SureScripts and eClinicalWorks. The purpose of this Authorization is to permit SSA to provide prescription and prescription history information to a national electronic clearing house of such information to facilitate accessibility to and exchange of such information among my various health care providers and third party pharmacy program payors for purpose of my treatment, reimbursement for prescriptions, and for any related purpose. I also authorize Salem Surgical Associates to obtain my prescription history through SureScripts. This consent will expire on termination of my status as a patient of Salem Surgical Associates

5. The assistant working with the physician is termed "nurse," however, that person may be a Medical Assistant, CNA, or other person trained by Salem Surgical Associates to work in that capacity.

6. I acknowledge being offered Salem Surgical Associates' Notice of Privacy Practices.

I acknowledge that I have read Sections 1 through 6 listed above.

____ _____________________

Signature of Patient or Patient's Representative Date

____

Printed Name of Patient's Representative