EYE CARE & SURGERY, P.C.

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Patient Name

Acknowledgement OF RECEIPT OF PRIVACY
NOTICE/AUTHORIZATION FOR RELEASING INFORMATION

I have been presented with a copy of this practice's **NOTICE OF PRIVACY POLICIES**, detailing how my information may be used and disclosed as permitted under federal and state law.

I hereby authorize Eye Care & Surgery to disclose any and all information necessary in the customary and normal procedures of the office as listed in the privacy notice. I realize I have the right to restrict who may have access to this information and may do so by submitting any restrictions in writing.

_____Date_____

Signature of Patient or Parent/Guardian (if Patient is a minor)

_____Date_____

Authority (if not signed by Patient)

REQUEST/CONSENT TO DISCLOSE HEALTH INFORMATION

I hereby request that health information be discussed with and disclosed to the family members, relatives, or friends listed below. The individuals identified below are involved in my care and/or payment for my care, and I agree that the provider listed above may share such information as the provider may deem relevant to such individual's involvement, including appointment times, required care and diagnoses. I understand that I have the right to revoke this request/consent by delivering written notice to the provider.

Please list individuals: _____

_____Date_____

Signature of Patient or Parent/Guardian (if Patient is a minor)

_____Date_____

Authority (if not signed by Patient)

Deemed Consent to HIV Testing: In case a health care worker of this clinic should be stuck by a needle or is directly exposed to fluids during your care which may transmit HIV virus, in accordance with Section 32.1 - 37.2 of the Virginia Code, you will be deemed to have consented to the clinic's right to draw blood for testing of the HIV virus and the release of such test results to the clinic and the worker who suffered the exposure.

_____Date_____

Signature of Patient or Parent/Guardian (if Patient is a minor)