CHARLOTTESVILLE BLUE RIDGE DENTAL

2320 Commonwealth Drive
Charlottesville, VA 22901
Office: 434-978-1510 Fax: 434-978-2857

Consent

I give this office/clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies and for health care operations like quality reviews.

I have been informed that I may review the practices/clinic's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice/clinic is not required to agree to this request. If the practice/clinic agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

I give this office permission to share my personal information and treatment with the following person(s).

_____ _____

_____ _____

Notice of Deemed Consent for HIV, HBV, and HCV testing

If one of our health care professionals, workers, or employees should be directly exposed to your blood or body fluids in a way that may transmit disease, your blood will be tested for infection with Human Immunodeficiency Virus and for the presence of the Hepatitis B and Hepatitis C Viruses. A physician or other healthcare provider will tell you and that person the results of the test.

Signature: _____ Date: _____
Patient, parent, or legal guardian

If signed by patient representative, state relationship to patient: _____