BLUE RIDGE EAR, NOSE, THROAT & PLASTIC SURGERY, INC.

Authorization for Release of Information

Name of Patient _____ **Date of Birth**_____

Blue Ridge ENT & PS, Inc. is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

ENTITY TO RECEIVE INFORMATION — **PERMISSION FOR THE FOLLOWING CIRCLE ALL THAT APPLY**

☐ Spouse (provide name and phone number)

_____

• Bring in for appointment • Seek medical advice • Obtain lab results
• Pickup prescripts/forms • Discuss financial/insurance info

☐ Other (provide name and phone number)

_____

• Bring in for appointment • Seek medical advice • Obtain lab results
• Pickup prescripts/forms • Discuss financial/insurance info

Blue Ridge ENT & PS, Inc. (BRENT) is dedicated to protecting the privacy of our patients. Except where required by law, BRENT will NOT authorize treatment, disclose, or discuss any information regarding your/your child's health or financial information with anyone other than the parent or legal guardian, unless otherwise listed below. **Please consider adding certain people such as grandparents, relatives over the age of 18, babysitters, or other care providers that may need to seek treatment or advice in your absence.**

MOTHER / LEGAL GUARDIAN NAME: _____

FATHER / LEGAL GUARDIAN NAME: _____

NAME	Relationship to Patient	Phone #	Permission for the following: Circle all that apply
			• Bring in for appointment • Seek medical advice • Pickup prescripts/forms • Obtain lab results • Discuss financial/insurance info
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I elect to receive communication such as appointment reminders, lab results, forms, etc. by:
(check all that apply) ☐ **Voice mail** ☐ **Text** ☐ **Email** ☐ **Fax**

For email and/or text communication I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.

Blue Ridge ENT & PS, Inc., may post photos received from parent or legal guardian in office: yes no

CONSENT: I consent to allow the providers, nurses, and employees of Blue Ridge ENT & PS, Inc., to perform all duties to diagnose, treat, and care for my/my child's health needs. I also understand that I have the right and responsibility to take part in making decisions regarding my/my child's care and plan for treatment.

DEEMED CONSENT: As a health care provider, we are required by § 32.1-45.1 of the Code of Virginia (1950), as amended, to give you the following notice: 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 ("HIV, the AIDS" virus) and for the presence of the Hepatitis Band Hepatitis C viruses. A physician or other health care provider will tell you and that person the result of the test and provide counseling, if necessary.If you should be directly exposed to blood or body fluids of one of our health care professionals, workers, or employees in a way that may transmit disease, that person's blood will be tested for infection with human immuno-deficiency virus ("HIV, the AIDS" virus) and for the presence of the Hepatitis Band Hepatitis C viruses. A physician or other health care provider will tell you and that person the result of the test and provide counseling, if necessary.

PATIENT RIGHTS: I have the right to revoke this authorization at any time. I may inspect or obtain a copy of the protected health information to be disclosed as described in this document. Revocation is not effective in cases where the information has already been disclosed but will be effective going forward. Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I have the right to refuse to sign this authorization and my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by patient/parent/guardian, or at the time the minor child reaches 18 years of age.

_____ _____

Signature of Patient or Personal Representative Date

_____

Description of Personal Representative's Authority (attach necessary documentation)

_____ _____ _____

Signature of Mother/Legal Guardian Relationship to Patient Date

_____

Print Name of Mother/Legal Guardian

_____ _____ _____

Signature of Father/Legal Guardian Relationship to Patient Date

_____

Print Name of Father/Legal Guardian