Salem Surgical Associates

Patient Name: _____ DOB: _____

1. **Notice of Deemed Consent to HIV Blood Testing**: Should an employee be exposed to my blood/body 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 body fluid may be tested for evidence of infection according to Virginia State Law.

2. **Release of Medical Information or Related Data:** I hereby authorize Salem Surgical Associates to release or 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 other designated person.

3. Salem Surgical will maintain a patient record 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 Salem Surgical, in writing, except to the extent is 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 as well as to employees and agents of Sure Scripts and eClinicalWorks. The purpose of this Authorization is to permit SSA to provided 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 purposes of my treatment, reimbursement for prescriptions, and for any related purpose. I also authorize Salem Surgical to obtain my prescription history through Sure Scripts. This consent will expire on termination of my status as a patient of Salem Surgical.

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 to work in that capacity.

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

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

_____ _____

Signature of Patient or Patient's representative Date

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Printed name of Patient or representative