BLUE RIDGE
ORTHOPAEDIC &
SPINE CENTER

Patient Consent and Release of Information

I understand and have been provided with a ***HIPPA Privacy Notice*** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I authorize Blue Ridge Orthopaedic & Spine Center to release my protected health information to the person(s) listed below over the phone, in person or via mail. This authorization shall expire two years from the date of signature.

□**Self:** _____
□**Spouse/Significant Other:** _____
□**Adult Child:** _____
□**Primary Care Physician:** _____
□**Specialist:** _____
□**Other:** _____

□**No release of medical information at this time**

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to the practice's Privacy Officer at 52 West Shirley Avenue, Warrenton Virginia, 20186. Revocations are not effective until received by the Privacy Officer. The revocation must include the patient's account number, name, address, the date of the original authorization, the recipients of the original authorization, the date of the revocation and the patient's signature. Blue Ridge Orthopaedic & Spine Center will accept written revocations of this authorization via: U.S. mail, in person, or by fax.

Patient Contact

As part of my health care treatment, I understand the office may try to contact me by phone. **Please check the following:**

- Yes ☐ No ☐ It is acceptable to leave a message regarding my protected health information including test(s) results on my voicemail.
- Yes ☐ No ☐ It is acceptable to leave a message regarding my protected health information including test(s) results with a member of my household.
- Yes ☐ No ☐ It is acceptable to discuss my protected health information with the emergency contact person that I have listed in the event that the office cannot reach me at the home/work number(s) that I have provided.
- Yes ☐ No ☐ It is acceptable for a member of my household to pick up my written prescription.

Advance Directive, Living Will, Do Not Resuscitate

Our physicians and medical providers honor our patients' end-of-life wishes, including Advance Directives, Living Wills and resuscitation desires. **Please check the appropriate section if you have any of the following documents.**

_____Advance Directive _____Living Will _____Do Not Resuscitate (DNR) _____Not applicable

Prescription Eligibility Acknowledgment

I am aware Blue Ridge Orthopaedic Associates and it's aaffiliated Providers will be obtaining prescription eligibility information at each office visit. This will provide basic prescription benefits and history information from my insurance (if applicable) for prescribing purposes.

I fully understand and accept/decline the terms of this consent listed above.

_____ _____
Patient/Guarantor Signature Date