DALEWOOD MEDICAL CENTER

PATIENT CONSENT FOR MEDICAL TREATMENT AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I understand that I have the right to make informed decisions about my health care treatment. I agree to have the providers and staff do tests and treatments they feel are needed for my care. These may include x-rays, lab tests, vital signs, medication and other therapy. I know other treatments or tests that have more risk will be explained to me so I can give informed consent for them if I need them. I know I can ask my doctor any questions I have about my treatment. I know that Dalewood Medical Center is not responsible for any of my belongings that I choose to keep with me.

I hereby give my consent for Dalewood Medical Center to use and disclose protected health information about me to carry out treatment, payment and health care operations. Dalewood Medical Center's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review Dalewood Medical Center's Notice of Privacy Practices prior to signing this consent. Dalewood Medical Center reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dalewood Medical Center at 4158 Dale Blvd, Woodbridge, VA, 22193.

With this consent, Dalewood Medical Center may call my home, send e-mail or mail to my home or other alternative location, and leave a message on voice-mail or in person in reference to any items that assist the practice in carrying out treatment, payment and health care operations. These items include, but are not limited to: appointment reminders, insurance items, correspondence from medical and/or nursing staff, any calls pertaining to clinical care, including laboratory results, and billing statements.

I have the option to request that Dalewood Medical Center restrict how it uses or discloses my personal health information to carry out treatment, payment and health care operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Dalewood Medical Center use and disclosure of my personal health information to carry out treatment, payment and health care operations with those organizations and health providers necessary for my medical care.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Dalewood Medical Center may decline to provide treatment to me.

____________________________________	____________________________________
Signature of Patient or Legal Guardian	**Print Patient Name**
____________________________________	____________________________________
Patient's Date of Birth	**Date**