Consent for Treatment:

1. General Consent for Treatment.

I hereby authorize employees and agents of Infectious Diseases Physicians, Inc., including physicians, physician assistants, nurse practitioners, nursing and other staff members, to render medical evaluations and care to the patient indicated below.

I acknowledge that according to Virginia state law, I shall be deemed to have consented to the testing for infection with Human Immunodeficiency virus (HIV), Hepatitis B, Hepatitis C viruses should any healthcare provider, or any person employed by or under the direction and control of a healthcare provider, be directly exposed to my body fluids in connection with rendering care to the patient, in a manner which may, according to the current guidelines of the Center for Disease Control, transmit HIV, Hepatitis B, or Hepatitis C viruses. Test results may be released to the person exposed.

2. E-Prescribing Consent.

The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These include:

- **Formulary and benefit transactions** – Gives the prescriber information about which drugs are covered by the drug benefit plan.

- **Medication history transactions** – Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events. By signing this consent form, you are agreeing that this office can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

3. Other Consents.

Infectious Diseases Physicians Inc. participates in an affiliated teaching program; physicians may be assisted in patient care by residents, fellows and/or medical students. I understand I have the right to refuse residents, fellows or medical students be involved in my care and will notify my care provider (s) of any such decision.

4. Patient Information.

I authorize the practice to provide my insurance company of record with information (including both medical and billing information). This release will remain active in your electronic health record, and will not be cancelled unless there is written authorization from the patient to do so on file.
5. **Patient Portal.**

Infectious Diseases Physicians, Inc. utilizes a web portal as part of the electronic health record, which communicates information including but not limited to test results and visit summaries. You may activate your patient portal by providing our office with a current email address and completing the user registration process through eClinical Works. I understand that I may decide to opt out of participation at any time by notification in writing to IDP.

6. **Duration**

The duration of this consent is indefinite and continues until revoked in writing. **I understand that by not signing this consent, the patient will not be provided medical care except in the case of an emergency.**

Patient Name (please print): ___________________________________________

Date: ______________________

Signature of Patient, Parent or Legal Guardian: ____________________________

Relationship, if Guardian:
____________________________________________________________________________________

Contact Information, if Minor:  
________________________________________________________________________________

Family Address:  
________________________________________________________________________________

Guardian’s Telephone: Home Cell Work:
________________________________________________________________________________

In the event we do contact you, is it suitable to leave a message(s) in the following manner? (Check all that apply.)

☐ On Answering Machine ☐ With an Adult Household Member ☐ Exclusively With Patient  
☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐

Other: ___________________________________________________________________________

Provider Representative Signature/Witness: __________________________________________

Date: ______________