AMERICAN SELF

9930 Independence Park Drive
Richmond, VA 23233
Phone (804) 290-0060
Fax (804) 290-0206

Ruth L. Hillelson, MD, FACS
Chief of Plastic Surgery & Aesthetics
Terry L. Whipple, MD, FACS
Chief of Orthopaedics

Date: _____

Referred By: _____ How did you hear about us? _____

Patient Name: _____ Sex:_____

(First) (Middle) (Last)

Date of Birth: _____ Age: _____ Social Security #: _____ Marital Status:_____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Alt. Phone: _____

Is there a phone number where you would like us to be able to leave messages that may contain private health care

Information? YES or NO (Please circle one) If yes, which number: _____

Personal E-mail Address: _____ May we e-mail you office news?_____

May we join you on Facebook? _____Facebook Name:_____

Employer: _____ Occupation: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact: _____ Relationship: _____

Address: _____

Phone: _____ Alternate Phone: _____

Pharmacy Name: _____ Pharmacy Phone: _____

Initial Visit Information

Reason for Today's visit: _____

If your injury is related to an accident, please provide the following information:

____Auto ____Workers Comp Claim Number: _____ Date of Initial Exam: _____

Date of Accident:_____ Time of Accident: _____

Contact Person: _____ Phone Number: _____

(Registration Continues On Next Page)

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Insurance Policies

Primary Insurance Carrier: _____ ID Number:_____

Subscribers Name: _____ Subscribers ID Number: _____

Group #: _____Subscribers DOB: _____ Relationship To Patient: _____

Subscribers Employer: _____ Employers Phone #: _____

Secondary Insurance Carrier: _____ ID Number: _____

Subscribers Name: _____ Subscribers ID Number: _____

Group #: _____Subscribers DOB: _____ Relationship To Patient: _____

Subscribers Employer: _____ Employers Phone #: _____

RECEIPT OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT

I, _____, HAVE RECEIVED A COPY OF AMERICAN SELF'S NOTICE OF PRIVACY PRACTICES.

COPY OF INSURANCE CARD & VIRGINIA STATE LICENSE

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS. THE RESPONSIBLE PARTY IS RESPONSIBLE FOR ALL COPAYS AND THOSE CHARGES DENIED BY THE INSURANCE FOR ANY REASON REGARDLESS OF INSURANCE COVERAGE. COPAYS ARE DUE THE DAY SERVICES ARE RENDERED AS WELL AS NON-COVERED CHARGES BY YOUR INSURANCE, WHICH ARE TO BE PREDETERMEND BY THE PATIENT IN ADVANCE OR VERIFIED BY AMERICAN SELF. I ALSO ACKNOWLEDGE THAT I AM THE RESPONSIBLE PARTY UNLESS I HAVE NOTIFIED AMERICAN SELF IN WRITINGIN ADVANCE OF SERVICES.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I HERBY AUTHORIZE AMERICAN SELF TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HERBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MY DEPENDANTS. I UNDERSTAND THAT I, THE RESPONSIBLE PARTY AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. I FURTHER AGREE TO PAY ALL COST OF COLLECTION, INCLUDING ATTORNEY FEES, COURT FEES, REGARDLESS IF SUIT IS BROUGHT OR NOT, IN THE EVENT THAT PAYMENT FOR SERVICES RENDERED IS NOT MADE WHEN BILLED OR AT THE TIME OF SERVICE.

_____	_____	_____
RESPONSIBLE PARTY SIRNATURE/PATIENT	RESPONSIBLE PARTY PRINTED NAME/PATIENT	DATE

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Patient Medical History

Patient Name:_____ Date of Birth: _____
Sex: _____ Height: _____ Weight: _____ Age: _____

1. Do you smoke? Y or N
2. Do you drink? Y or N
3. Are you allergic to tape? Y or N
4. Are you allergic to latex? Y or N
5. Do you have a pacemaker? Y or N
6. Are you currently in good general health? Y or N
7. Are you currently being treated for any illness? Y or N
    a. If yes, please explain:

    _____

    _____

8. When was the last time you had a physical? _____
9. Who is your Primary Care Physician: _____ Phone: _____
10. Please list all past serious illnesses & major surgeries:

    _____

    _____

    _____

11. Have you ever had a blood transfusion? Y or N
12. Are you allergic to any medications? Y or N
    a. If you please list those medications that you are allergic to:

    _____

    _____

    _____

13. Have you ever had a reaction to anesthesia? Y or N
14. Is it possible that you may be pregnant? Y or N
15. Are you currently taking Aspirin? Y or N
16. If yes when was it last taken, and what was the strength?

    _____

17. Are you currently taking Retin A (Tretinoin)? Y or N
18. Are you currently taking blood thinners/anticoagulants? Y or N
    a. If yes when was it last taken, and what was the strength?

    _____

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19. Please list all other medications that you are currently taking:

Med: _____ Dosage: _____ Frequency_____

Med: _____ Dosage: _____ Frequency_____

Med: _____ Dosage: _____ Frequency_____

Med: _____ Dosage: _____ Frequency_____

Med: _____ Dosage: _____ Frequency_____

Med: _____ Dosage: _____ Frequency_____

Med: _____ Dosage: _____ Frequency_____

20. Do you have any other health-related information that you would like the physician to be aware of?

a. Please explain:

_____
_____
_____
_____
_____
_____

21. Do you have Mitral Valve Prolapse (heart condition)?

a. IF YOU DO HAVE MITRAL VALVE PROLAPSE AND YOU ARE PLANNING ON US DOING ANY PROCEDURE ON YOU, PLEASE CHECK WITH YOUR PRIMARY CARE PROVIDER OR YOUR CARDIOLOGIST TO SEE IF YOU WILL REQUIRE ANTIBIOTIC PRIOR TO ANY PROCEDURE, AS THEY WILL NEED TO PRISCRIBE THE MEDICATION THEY FEEL WILL BE NECESSARY.

_____ _____
PATIENT SIGNATURE DATE

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Notice Of Privacy Practices

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Last Revised: Tuesday, January 28, 2003

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU AND YOUR CHILDREN (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

THESE POLICIES BECOME EFFECTIVE APRIL 14, 2003

PLEASE REVIEW THIS NOTICE CAREFULLY.

Note: In this document the term "you" refers to the children we provide care for as well as their parents, legal guardians, and/or caretakers.

A. OUR COMMITMENT TO YOUR PRIVACY
Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.
We realize that these laws are complicated, but we must provide you with the following important information:

1. How we may use and disclose your IIHI
2. Your privacy rights in your IIHI
3. Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, on our website, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Privacy Officer
American Self
9930 Independence Park Drive
Richmond, VA 23233
(804) 290-0060

C.WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS
The following categories describe the different ways in which we may use and disclose your IIHI.

1. Treatment. Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents.
Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for
our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.

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4. Appointment Reminders. Our practice may use and disclose your IIHI to contact you and remind you of an appointment.
5.Treatment Options. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.
6. Health-Related Benefits and Services. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.
7. Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.
8. Disclosures Required By Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:
    1. maintaining vital records, such as births and deaths
    2. reporting child abuse or neglect
    3. preventing or controlling disease, injury or disability
    4. notifying a person regarding potential exposure to a communicable disease
    5. notifying a person regarding a potential risk for spreading or contracting a disease or condition
    6. reporting reactions to drugs or problems with products or devices
    7. notifying individuals if a product or device they may be using has been recalled
    8. notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
    9. notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.
2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.
4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:
    1. Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
    2. Concerning a death we believe has resulted from criminal conduct
    3. Regarding criminal conduct at our offices
    4. In response to a warrant, summons, court order, subpoena or similar legal process
    5. To identify/locate a suspect, material witness, fugitive or missing person
    6. In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.
6. Organ and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.
7. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.
8. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
9. Military. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
10. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to Federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.
11. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.
12. Workers' Compensation. Our practice may release your IIHI for workers' compensation and similar programs.

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Chief of Orthopaedics

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to Privacy Officer American Self 9930 Independence Park Drive Richmond, VA 23233 specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to Privacy Officer American Self 9930 Independence Park Drive Richmond, VA 23233. Your request must describe in a clear and concise fashion:

(a)the information you wish restricted;
(b)whether you are requesting to limit our practice's use, disclosure or both; and
(c)to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Privacy Officer American Self 9930 Independence Park Drive Richmond, VA 23233in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is
kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Privacy Officer American Self 9930 Independence Park Drive Richmond, VA 23233. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment, non-payment or non-operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to Privacy Officer American Self 9930 Independence Park Drive Richmond, VA 23233. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. This privacy notice will also be available online at www.americanself.com. To obtain a paper copy of this notice, contact Privacy Officer American Self 9930 Independence Park Drive Richmond, VA 23233.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Privacy Officer American Self 9930 Independence Park Drive Richmond, VA 23233. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.
Again, if you have any questions regarding this notice or our health information privacy policies, please contact Privacy Officer American Self 9930 Independence Park Drive Richmond, VA 23233.

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Ruth L. Hillelson, MD, FACS
Chief of Plastic Surgery & Aesthetics
Terry L. Whipple, MD, FACS
Chief of Orthopaedics

Medical Services Contract

I hereby authorize Ruth L. Hillelson, M.D., F.A.C.S., and/or Terry L. Whipple, M.D., F.A.C.S. to render medical services to myself (and/or dependent (s)) and to release any information regarding my claim for benefits. I also understand that Ruth L. Hillelson, M.D., F.A.C.S., and/or Terry L. Whipple, M.D., F.A.C.S. make no guarantee with respect to the outcome of said medical services. I also understand that any possible cosmetic surgery revisions are without surgical charges for one year. I authorize payment directly to Ruth L. Hillelson, M.D., F.A.C.S., and/or Terry L. Whipple, M.D., F.A.C.S., may, but is/are not required, to file a claim with any and all policies of my insurance. If the insurance company payment is not made in a timely manner, I understand that it is my responsibility to pay any outstanding bill(s) and to persue, myself, recovery of expenses with the insurance company. I understand that I am financially responsible for all charges arising for treatment and/or services.

The undersigned hereby assigns to Ruth L. Hillelson, M.D., F.A.C.S., and/or Terry L. Whipple, M.D., F.A.C.S., any and all rights and benefits they may have under any policy of insurance (major medical, automobile, hospitalization, worker's compensation, or any other) and herby authorize Ruth L. Hillelson, M.D., F.A.C.S., and/or Terry L. Whipple, M.D., F.A.C.S., to release whatever medical information is necessary to perfect a claim under such policy, and further direct any such insurance company to make payment of benefits to Ruth L. Hillelson, M.D., F.A.C.S., and/or Terry L. Whipple, M.D., F.A.C.S.

The undersigned agree(s) to: a.) to pay upon demand by Ruth L. Hillelson, M.D., F.A.C.S., and/or Terry L. Whipple, M.D., F.A.C.S., the entire balance due under terms of this agreement; b) in the event the undersigned fail to pay on demand to Ruth L. Hillelson, M.D., F.A.C.S., and/or Terry L. Whipple, M.D., F.A.C.S., and the account is turned over to a collection agency and attorney for collection, to pay reasonable collection costs and expenses including, but not limited to, any collection agency fees and attorney's fees, in the amount of thirty percent (30%) of the total indebtedness plus court cost. If this indebtedness is not paid in full within sixty (60) days, I agree to pay a service charge of one and one-half percent (1 ó %) per month, eighteen percent (18%) per annum. c) that for the purpose of the assignments and authorizations contained herein, a photocopy of the original executed document shall be as valid as the original and any and all persons affected by the assignments and requesting an authorization may rely on any such copy.

The undersigned agrees to grant Ruth L. Hillelson, M.D., F.A.C.S., and/or Terry L. Whipple, M.D., F.A.C.S., an irrevocable lien on any and all Medpay insurance I may have or to which I may otherwise be beneficiary to. In the event that my (or dependent's) illness or injury or need for treatment and/or services has arisen out of an occurrence for which a third party is, or may be, responsible, I herby grant Ruth L. Hillelson, M.D., F.A.C.S., and/or Terry L. Whipple, M.D., F.A.C.S. and irrevocable lien on any recovery against said third party in any amount equal to the total of all due plus contract interest and attorney fees if the bill/account has been turned over to an attorney for collection. I acknowledge that there has been no representation or agreement by Ruth L. Hillelson, M.D., F.A.C.S., and/or Terry L. Whipple, M.D., F.A.C.S., that he/she/they will withhold collection against me pending settlement of such claim. The undersigned acknowledges that the Physician(s) have determined that he/she is in the principal profession of providing quality medical care, not testifying as a witness in legal proceedings. The physician(s) has/have further determined that the client/patient and all of the physician's other client/patients are best served by the Physician's express policy to decline, to the fullest extent permitted by law, to provide testimony as a witness in any type of legal proceeding. In the event that the Physician(s) is/are compelled to testify she/he may, at her/his option, appear only as a witness to the fact and accordingly interpret what is in the client/patient records for the court. She/he, at her/his option, may not wish to offer any expert opinion. The Client/Patient consents to and agrees to abide by this policy. The Client/Patient further acknowledges that in the event that a physician(s) is/are compelled to testify in connection with any such legal process, the Client/Patient agrees to be responsible for payment of fee for the Physician(s) testimony.

_____ _____ _____

RESPONSIBLE PARTY SIGNATURE/PATIENT RESPONSIBLE PARTY PRINTED NAME/PATIENT DATE

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Chief of Orthopaedics

Authorization for Release of Medical Records

Patient Name: _____ DOB: _____

Patient Address:
_____

City: _____ State: _____ Zip Code: _____

I herby request that a copy of my complete medical records should be released from:
_____, and that a copy be sent to:

American Self – Orthopaedics & Plastic Surgery.
Attn: Medical Records
9930 Independence Park Drive
Richmond, VA 23233
Fax: 804-290-0206

This document complies with all requirements as outlined in Health Insurance Portability and Accountability Act of 1996 (HIPAA) – Federal Privacy Rule. This request shall remain in effect until revoked in writing.

_____ _____ _____
SIGNATURE GUARDIAN/PATIENT PRINTED NAME GUARDIAN/PATIENT DATE