

Clarksville Primary Care Center, Clarksville VA
A Service of VCU Community Memorial Hospital

CONSENT FOR TREATMENT

I, the undersigned, authorize the performance of any medical or surgical procedure including but not limited to, medical examinations, immunizations, therapeutic injections, invasive or surgical procedures and other medically appropriate/necessary services advised by the Physicians and Nurse Practitioner of Clarksville Primary Care Center, for the patient named on this form.

The undersigned has been informed of the risks involved, has read the above consent for treatment and understands the same and certifies that no guarantee or assurances have been made as to the results that may be obtained.

The following consent section (HIV/TB Testing) is needed for situations where the staff may be exposed to any of the patients' bodily fluids. This is not saying that we will test you for HIV or TB.

NOTICE OF DEEMED CONSENT TO HIV BLOOD TESTING OR TUBERCULOSIS (TB) TESTING

I, the undersigned, authorize Clarksville Primary Care Center to test me for Human Immunodeficiency Viruses (HIV) antibodies or Tuberculosis (TB) when the doctors or any employees are exposed to body fluids in a manner in which may transmit HIV, or infection or TB.

In the event of such exposure, you will be deemed to have consented to such testing, and to have consented to the release of the test to the person(s) who may have been exposed.

Patient or Parent/Guardian Signature

Date

Printed Name

Signature of Legal Representative

Date

If signed by legal representative, relationship of Representative to Patient