CULPEPER WELLNESS foundation
Free Clinic of Culpeper

FREE CLINIC OF CULPEPER

CONSENT FOR TREATMENT

I, the undersigned, authorize treatment by the health care providers and staff of the Free Clinic of Culpeper. I understand some of the health care providers are volunteers.

_____	_____	_____
Patient Signature	Clinic Representative	Date

HIV/HEPATITIS CONSENT

In the event that a health care provider or anyone providing patient care at the Free Clinic of Culpeper is directly exposed to my bodily fluid I consent to be tested for HIV/Hepatitis. I understand that the results will be released to the person who was exposed to my bodily fluids.

_____	_____	_____
Patient Signature	Clinic Representative	Date

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I, the undersigned, grant the Free Clinic of Culpeper permission to release my medical information only to other physicians and clinical providers that are directly involved with my care. Any other request for medical information will need my specific permission to release my medical information.

_____	_____	_____
Patient Signature	Clinic Representative	Date