Bluepoint
MEDICAL ASSOCIATES
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Suite 413
703.385.8222
CENTREVILLE

2080 Old Bridge Road
Suite 101
703.385.8222
LAKERIDGE

Patient Contact Authorization

❖ I wish to be contacted in the following manner (check all that apply):

☐ Home Phone: _____ ☐ Work Phone: _____ ☐ Cell Phone: _____

☐ Ok to leave a detailed message
☐ Leave message with call back number only

☐ Email (for Patient Portal & appointment confirmations only): _____
☐ Text (for appointment confirmations only): _____

***You may discuss my medical history with:**
In accordance with Federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information released and/or discussed with members of you or other individuals that you designate, we must obtain your authorization/consent prior to doing so. Complete and sign below if you wish to give your consent.

_____ _____ _____
Name Telephone Relationship to patient

☐ I do NOT wish to authorize discussion or disclosure of my results to anyone else.

Print Name: _____ Signature: _____ Date: _____

Consent for Photos

I _____, hereby authorize *Bluepoint Medical Associates* to use and publish before and after photographs of me in whole or in part, in any publication, newspaper, compilation, magazine, book, volume or medium and to make any reproductions or republications of the a photograph, in whole or in part and without limitation as to time or number of such publications, reproductions or republications, as the Publisher (*Bluepoint Medical Associates*) desires in its discretion. The Publisher has the right to retain an electronic or other copy of the photograph and to use the image of the photograph for any editorial or promotional or other purposes, whether for profit or not for profit in any publication, newspaper, compilation, magazine, book, volume or medium (collectively the "Publications") at the Publisher's discretion. I represent to the Publisher that I am the owner of the photograph, that I have full authority to give the consent to the use thereof to the Publisher and that the Publisher will not violate any state or federal law by use of this photograph. To the extent I claim any copyright in the photograph, I expressly grant the Publisher a license to use, publish, republish or reproduce the photograph, in whole or in part, in any publication. I release the Publisher, its successors and assigns and all persons acting under their permission or authority, from any liability for any publication, alteration or damage to the photograph. The Publisher may retain the original photograph.

I understand that not all submitted photographs will be published and I agree that the Publisher has the sole discretion to publish, republish or reproduce the photograph and whether to credit the author or photographer of the photograph in any publication, reproduction on or republication of the photograph.

☐ **DECLINE**

_____ _____
Signature of Patient or Personal Representative Date