



0100000

PLACE LABEL HERE.

IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

SHARED MEDICAL APPOINTMENT AUTHORIZATION**How is my privacy handled in a shared medical appointment?**

Privacy is a concern for almost everyone when they come to a shared medical appointment. During shared medical appointments, your medical issues will be discussed in front of others. And you will hear about other participants' health issues and personal information.

It is your duty to keep everything you hear confidential. Nothing that identifies a participant in any way (including job, ethnicity, religion, etc) should be shared outside of this group setting. Of course, you are welcome to discuss things you find helpful with friends and family, providing nothing that you say identifies other participants.

Can I withdraw from a shared medical appointment?

Shared medical appointments allow patients to spend more time with their physician and gain helpful information. Many patients who try this type of visit will want to return, but you are under no obligation to do so.

You always have a choice in the type of care you would like to receive. This includes the shorter, traditional individual visit.

Shared Medical Appointment Authorization

Appointment with _____ on _____

- I agree to participate in the shared medical appointment described above.
- I authorize my physician and his/her colleagues to discuss my health issues and other personal information with the other participants in the appointment.
- I understand that the participants in the appointment may ask questions of and volunteer personal information to and about each other.
- I also understand that the appointment participants may disclose my health issues and other personal information to others outside the appointment. I understand that state and federal privacy laws will not prevent this disclosure.
- I understand that the quality of care I receive from the UVA Health System will not be affected by whether or not I sign this authorization form.

Patient Name (please print): _____

Patient Signature: _____ Date _____

Support Person Name (if present): _____ Date _____

Reviewed by staff Name: _____ Date _____

This authorization will terminate ten years from the date of signature.

Each participant will be asked to sign and given a copy of this authorization before each shared medical appointment.

WHITE COPY – HIS YELLOW COPY – PATIENT