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Deemed Consent for Designated Blood Borne Pathogens

Virginia law requires health care providers to notify you that Hepatitis B and C or HIV (Aids) Virus testing on a sample of your blood may be done if a health care worker is exposed to your blood or body fluids. This following notice is to advise you that this is in effect at this facility.

As a health care provider under the Virginia Acts of Assembly Section 32.1-45.1, whenever any healthcare worker associated with or working for Family Dermatology of Albemarle PLC is directly exposed to body fluids of a patient in a manner which, according to the guidelines of the Centers for Disease Control, may transmit Human Immunodeficiency Virus (Aids) or Hepatitis B and C, Family Dermatology of Albemarle PLC will proceed to test the patient through his or her physician and to the health care worker(s) who was/were exposed.

When a person is tested, we automatically test for HIV and Hepatitis B and C for the safety of all concerned. This policy protects you as a patient, should you be exposed.

Consent to Medical Care

I voluntarily consent to medical care at Family Dermatology of Albemarle which may include examinations, tests, photographs, and treatments by Dr. Krasner and staff. No promises have been made to me as to the results of treatment or examinations.

Parental Consent for Child Under 18 Years of Age

I am present with my child _____ today and I give my consent to Dr. Krasner to see and treat my child as indicated. I give my permission for continued follow-up care which may include changes to the treatment plan in my absence. (No invasive procedures will be performed without direct notification to the parent.)

Consent to the Use and Disclosure of Health Information for Treatment, payment or Healthcare Operations

I acknowledge that I have been offered and/or received a copy of Family Dermatology of Albemarle's Notice of Privacy Practices.

Signed: _____ Date: _____