Orthopedic Associates of Lancaster
170 North Pointe Blvd. • Lancaster, PA 17601
212 Willow Valley Lakes Dr. • Suite 201 • Willow Street, PA 17584
Telephone (717) 299-4871 Fax (717) 391-2494

VOLUNTARY CONSENT TO TREATMENT

I do hereby voluntarily consent to permit any associated physician or assistant of OAL to perform an examination and any diagnostic procedures, including such medical/surgical procedures as are necessary or advisable in their judgment for my medical care.

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Initial

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that I have received the Notice of Privacy Practices for Orthopedic Associates of Lancaster, LTD.

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Initial

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize the physicians and staff of OAL to release and communicate information to the parties listed below regarding my treatment in order to maximize the coordination of my medical care and to provide ongoing communications.

Name of Physician	Address/location	Phone#
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family Member or Other	Relationship	Phone #
_____	_____	_____
_____	_____	_____

I authorize records relating to all problems to be released to the above listed entities unless otherwise indicated.

I understand that this authorization is valid until I notify OAL in writing or in person that I wish to discontinue the communication with these entities

☐ I do not wish my records to be released to my family physician

_____ _____
Signature Date