ORTHOPEDIC ASSOCIATES OF LANCASTER, LTD
Experienced, Specialized Care

**Patient:** _____

**DOB:** _____

**MRN:** _____

**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 to maximize my medical care coordination and provide ongoing communications in accordance with HIPAA regulations.

| Family Member or Other: | Relationship: | Phone #: |
|---|---|---|
| 1)_____ | _____ | _____ |
| 2)_____ | _____ | _____ |
| 3) _____ | _____ | _____ |

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.

| _____ | _____ | _____ |
|---|---|---|
| Signature | Print Name | Date |