ORTHOPEDIC ASSOCIATES OF LANCASTER, LTD

Patient: _____

MRN: _____

VOLUNTARY CONSENT TO TREATMENT

I do hereby voluntarily consent to permit any associated physician or assistant of Orthopedic Associates of Lancaster (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.

_____ Initial

ACKNOWLEDGMENT OF RECEIPT OF AUDIO/VIDEO RECORDING POLICY & NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that I have received the Audio/Video Recording Policy & Notice of Privacy Practices for OAL.

_____ 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 to maximize my medical care coordination and provide ongoing communications.

Name of Physician:	Address/Location:	Phone #:

Family Member or Other:	Relationship:	Phone #:

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	Print Name	Date

Orthopedic Associates of Lancaster complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Orthopedic Associates of Lancaster cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (717) 299-4871.

Orthopedic Associates of Lancaster 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (717) 299-4871.