Orthopedic Associates of SW Ohio
www.oaswo.com 1-800-824-9861

Orthopedic Associates of SW Ohio (OASWO)
AUTHORIZATION FOR TREATMENT

I Authorize Examination, Diagnosis, And General Treatment (Including, But Not Limited To, The Use Of TeleHealth, X-Rays And Other Non-Invasive Procedures Such As Diagnostic Tests) To Be Performed By Physicians And Staff Of OASWO. I Realize That If A Medical Procedure Or Surgery Is Required, I Will Be Given Additional Information.

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

I consent to OASWO using and disclosing my protected health information to carry out treatment, payment, or health care operations.

I understand and have been provided with a Notice of Privacy Practices, which provides a more complete description of how my protected health information may be used or disclosed. I understand that I have the right to review the notice prior to signing this consent. I understand that OASWO reserves the right to change their notice and information practices and that I may obtain a copy of the revised notice by requesting a copy from the office manager. I have the right to revoke this consent by notifying OASWO in writing, except to the extent that OASWO has taken action in reliance on my consent.

I hereby authorize any holder of medical information about me to release to the centers for Medicare/Medicaid services and its agents *any* information *needed* to determine those benefits payable for related services. I hereby authorize Medicare/Medicaid to furnish to OASWO any information regarding my Medicare claims under title xvii and xix of the social security act.

I, _____, whose signature appears below, authorize Orthopedic Associates of SW Ohio, Inc. and it's providers to view my external prescription history.

I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

I consent for medical photographs to be made of me or my dependent for whom I am legal guardian. I understand that the information may be used in my medical record, for purposes of medical teaching, or for publication in a medical textbook or journal. By consenting to medical photographs I understand that I will not receive any payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive.

MY SIGNATURE CERTIFIES THAT I HAVE READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I CONSENT TO UNDERSTANDING ALL OF THE ABOVE STATEMENTS.

_____ _____

Patient Signature Date