ARROWHEAD ORTHOPAEDICS
"A Tradition of Excellence"

CONSENT FOR MEDICAL TREATMENT
I give consent to Arrowhead Orthopaedics (AO), its staff, physicians and other practitioners to provide and perform such medical care, tests, procedures, and other services that are deemed necessary or beneficial by Arrowhead Orthopaedics for my health and well being. This also includes treatment of a minor (under the age of 18).

MEDICAL RECORD RELEASE
I hereby authorize any necessary medical records, prescription history, and/or diagnostic studies be released to Arrowhead Orthopaedics for management of my care.

NOTICE OF PRIVACY PRACTICES
I have been provided the *Notice of Privacy Practices*, which describes the use and disclosure of my protected health information that will occur during my treatment and bill payment. This *Notice of Privacy Practices* also describes my rights and the duties of Arrowhead Orthopaedics with respect to my protected health information.

RELEASE OF INFORMATION
I understand that Arrowhead Orthopaedics will release my health information: (1) to any requesting health care provider for my further diagnosis, care or treatment or for that provider's payment or health care operation purposes; (2) to any person or entity which may be responsible for billing/collection of claims for medical services or products; (3) to any person or entity which is, or may be liable to Arrowhead Orthopaedics or me for all or part of Arrowhead Orthopaedics' charges, including but not limited to, insurance companies, HMO or third party payors; (4) to any government agency or other organization responsible for oversight of Arrowhead Orthopaedics or a third party payor; (5) for Arrowhead Orthopaedics normal health care operations. I understand that Arrowhead Orthopaedics may communicate information including protected health information with me by phone, mail, through the AO Direct Patient Portal. I understand that to ensure continuity of care, all Arrowhead Orthopaedics' providers and staff will have access to the information in my electronic health record.

COMMUNICATION CONSENT (Check to confirm approval of method)
I agree to allow AO to contact me using the following method(s) regarding my personal health information, evaluation and treatment. AO is authorized to leave messages for me when I am not available as indicated below:

Preferred Method of Contact: ☐ Home ☐ Cell ☐ Work

☐ Home Phone: ( ) _____ Messages: ☐Yes ☐No
☐ Cell Phone: ( ) _____ Messages: ☐Yes ☐No
☐ Work Phone: ( ) _____ Messages: ☐Yes ☐No
☐ E-mail: _____

I authorize AO and medical staff to discuss my personal health information with the individuals listed below. I understand by leaving spaces blank, I am indicating my choice that I do not want my information shared with or released to anyone.

Name _____ Relation _____

Name _____ Relation _____

I HEREBY AGREE WITH AND CONSENT TO ALL OF THE ABOVE.

_____	_____	_____
Patient Name	Signature of Patient/Legal Representative	Date of Birth
_____	_____	_____
If signed by Legal Representative (print name)	Relationship to patient	Date