Daniel J. D'Arco, M.D. and
Pennsylvania Muscle Bone and Joint
111 S. Center St.
Pottsville, PA 17901
(570) 628-6858

VOLUNTARY CONSENT TO TREATMENT

I do hereby voluntarily consent to permit any associated physician or assistant of Dr. D'Arco and PA Muscle Bone and Joint (PAMBJ) 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 **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION** for PAMBJ

______ Initial **AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION** I hereby authorize the physicians and staff of Dr. D'Arco and PAMBJ 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/ Telephone

___________________________________ __________________ __________

Family Member or Other Relationship Telephone # ______________________________ ________

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 PAMBJ in writing or in person that I wish to discontinue the communication with these entities or I do not wish my records to be released to my family physician.

VOLUNTARY CONSENT TO TREATMENT I do hereby voluntarily consent to permit any associated physician or assistant of PAMBJ 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.

______________________________ ___________________ Patient Signature and Date

Witness _________________________