



**AUTHORIZATION OF TREATMENT/ASSIGNMENT OF BENEFITS/  
RELEASE OF INFORMATION/PRIVACY NOTICE**

*Before the patient signs this form, cross out and have patient initial paragraphs or blanks that do not apply.  
As much as possible, all explanations should be in everyday language.*

PATIENT:		DOB:	MEDICAL RECORD NUMBER:
DATE:	TIME:	LOCATION:	

**CONSENT FOR TREATMENT:** By this document, I do hereby request and authorize LVPG (Lehigh Valley Physician Group), its medical practices and providers including physicians, surgeons, technicians, nurses, and other qualified personnel to perform evaluation and treatment services and procedures as may be necessary in accordance with the judgment of the provider(s). I understand the explanation(s) given and I acknowledge that no guarantee can be given to me by anyone concerning the results of treatments, examinations or procedures.

**PRIVACY NOTICE:** I acknowledge receipt of the Health Information Privacy Notice for Lehigh Valley Hospital and Health Network and the Common Medical Staff of Lehigh Valley Hospital and Lehigh Valley Hospital-Muhlenberg on or after April 14, 2003.

**IMMUNIZATION REGISTRY:** I understand that LVPG participates in the Pennsylvania Department of Health's statewide immunization registry that collects vaccination history and information to serve the public health goal of preventing the spread of vaccine preventable diseases. The registry complies with federal health information privacy laws.

**INSURANCE AUTHORIZATION AND ASSIGNMENT:** I request that payment of authorized medical benefits is made on my behalf directly to the LVPG provider of all service(s) furnished to me. I authorize LVPG to release any medical information directly to my health insurance carrier and/or its legitimate agents that is necessary to process related health insurance claims and/or to determine plan benefits in accordance with HIPAA release of protected health information standards. Further, I authorize payment of service(s), otherwise payable to me under the terms of my private, group employer's or group health insurance plan, directly to the LVPG provider of service(s). I hereby authorize the photocopies of this form to be valid as the original.

**PAYMENT GUARANTEE:** I do hereby guarantee payment of all fees and charges related to all services and durable goods provided to me through LVPG medical practices and providers from my first date of examination or treatment. I agree to make full payment immediately upon receipt of an LVPG billing statement whether it is an interim or final bill. In the event that I fail to make full payment or fail to comply with other payment arrangements made with LVPG's approval, I understand that appropriate collection measures may be initiated.

**RELEASE OF RESPONSIBILITY FOR PERSONAL VALUABLES:** I have been made aware and understand that all LVPG medical practices and offices provide no facilities for safekeeping of valuables. I do hereby release LVPG from any responsibility due to loss or damage of any valuables that I, or anyone accompanying me, may bring to an LVPG medical practice, office or facility.

**PERMISSION TO FAX CHILDHOOD IMMUNIZATION RECORD TO SCHOOLS:** I do hereby grant permission for LVPG to send or fax childhood immunization records to schools, upon request.

I, or my legal representative, certify that I have read this document, that it has been fully explained to me and that I understand its contents, and hereby agree to all terms and conditions set forth above and acknowledge the receipt of a copy if requested

\_\_\_\_\_  
Signature of Patient/Guarantor/Agent

\_\_\_\_\_  
Relationship to Patient if applicable

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date of Signing