

**MARYSVILLE ARTHRITIS CENTER**

**CONDITIONS OF REGISTRATION**

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**CONSENT FOR TREATMENT:** I consent to the performance of all routine medical care and treatment (e.g. tests, therapy, medical treatment or procedures, etc.) which may be performed as deemed necessary by and under the general and special instructions of my/the physicians and/or authorized healthcare provider of the Marysville Arthritis Center.

**TRAINING** (if applicable): I understand that my physician office may participate in graduate medical education. I authorize the participation in my/the patient's medical care of physicians-in-training, under the direct supervision of the physician of Marysville Arthritis Center.

**RELEASE OF INFORMATION:** I agree that, to the extent necessary to determine liability for payment and to obtain reimbursement, or as otherwise permitted or required by law, Marysville Arthritis Center (MAC) may disclose any portion of my/the patient's medical records, including, but not limited to, information about my/the patient's diagnosis and/or treatment relating to medical, mental health, developmental disability, and/or substance abuse treatment to any person, regulatory or government agency, or corporation, including but not limited to insurance companies, health care service plans, or workers' compensation carriers, which are, or may be liable for, all or any portion of MAC's charges. To ensure coordination of my/the patient's ongoing care and treatment, I also authorize release of any medical information to my/the patient's primary care physician or healthcare provider and any consulting physicians or healthcare providers participating in my/the patient's care.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_