Patient Name: ________________________________ **DOB:** ________________________

Voluntary Consent to Treatment

________ I do hereby voluntarily consent to permit any associated physician or assistant of Lancaster Cancer Center,
Initials LTD to perform an examination and/or any procedure, including lab work, bone marrow biopsies, injections, and chemotherapy administration, etc. as necessary or advisable in their judgment for my medical care.

Authorization for Use or Disclosure of Health Information (HIPAA)

I hereby authorize the physicians of Lancaster Cancer Center, LTD to release and communicate information to the parties listed below regarding my treatment to maximize the coordination of medical care and to provide ongoing communications.

Notification Preference: □ **Home** ____________________ □ **Cell** ____________________ □ **Work** ____________________

Name of Physician	Address	Phone Number

Family Member or Other	Relationship	Phone Number

I understand that the office will call with reminder appointments. I understand that this is valid until I notify the office in writing or person that I wish to discontinue communication with these entities.

________________________________ ______________ ________________________

Patient Signature or Legal Representative **Date** **Witness**

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