Ocean Medical Imaging
of Delaware

Radiology you can trust.

Consent For Treatment

I consent to treatment with Ocean Medical Imaging of DE. I grant permission to the physicians, employees and other persons authorized by Ocean Medical Imaging of DE to render routine medical care that includes diagnostic imaging to carry out all orders deemed advisable by my attending or treating physician. I understand that no guarantee or assurance has been made as to the results that may be obtained.

I hereby consent to the use and disclosure of my health information for treatment, payment and health care operations purposes as described in Ocean Medical Imaging's Notice of Privacy Practices.

Acknowledgement of Receipt of Privacy Notice

I hereby acknowledge that I have received a copy of Ocean Medical Imaging's Notice of Privacy Practices.

Signature: _____

Date: _____