

Release of Patient Medical Information

(Initial) I give the physicians and staff of Comprehensive Blood & Cancer Center (CBCC) permission to discuss my treatment, diagnostic tests, medical condition with the following individuals:

(Initial) I give the physicians and staff of CBCC permission to discuss my Mental Health Records protected by Lanterman-Petris -Short Act with the following individuals:

Release Information to:

Name: _____
Relationship: _____
Phone: _____

Release Information to:

Name: _____
Relationship: _____
Phone: _____

Release Information to:

Name: _____
Relationship: _____
Phone: _____

Release Information to:

Name: _____
Relationship: _____
Phone: _____

I understand that if I wish to add or delete individuals from this list that I must notify CBCC in writing.

I authorize CBCC to leave test results on my voice mail:

Yes No

Home Phone: _____

Mobile Phone: _____

I authorize CBCC to fax test results to me:

Yes No

Fax Number: _____

I understand that if my telephone or fax number changes from this list that I must notify CBCC in writing.

This is an indefinite consent form unless otherwise specified.

Patient Name: _____

Patient Signature: _____

Date of Birth: _____

Date: _____