RELEASE OF PATIENT MEDICAL INFORMATION

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

_____ ☐ Mental Health Records Protected by Lanterman-Petris-Short Act with the following individuals:
(Initials)

Release Information to: _____

_____
Relationship Phone #

Release Information to: _____

_____
Relationship Phone #

Release Information to: _____

_____
Relationship Phone #

Release Information to: _____

_____
Relationship Phone #

I authorize CBCC to leave test results on my voice mail: Yes No (Circle one)
My telephone number's are: _____ _____

I authorize CBCC to fax test results to me: Yes No (Circle one)
My fax number is: _____

1. I understand that if I wish to add or delete individuals from this list that I must notify CBCC in writing.
2. I understand that if my telephone or FAX number changes that I must notify CBCC in writing.

THIS IS AN INDEFINITE CONSENT FORM UNLESS OTHERWISE SPECIFIED.

_____ _____
Patient Name (Please Print) Date of Birth

_____ _____
Patient Signature Date Signed

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