

Commonwealth Hematology-Oncology, P.C.

Site:

Address:

Phone:

Fax:

MEDICAL RECORD RELEASE CONSENT

Patient Name: _____

Address: _____

Date of Birth: _____ Social Security #: _____

I hereby authorize Dr. _____

Address: _____

To furnish information and/or medical records to:

Dr. _____

Address: _____

Specific Information to be enclosed: _____

This consent is effective for records from: _____

to: _____

Date: _____ Signature: _____

Witness: _____ Signature: _____

(Parent/Legal Guardian/Authorized Representative)

NOTE: Consent must be signed by the patient or the next of kin in case patient is a minor, or by legal guardian when the patient is physically or mentally incompetent. If consent is signed by other than the patient, please state the reason.