REGIONAL CANCER CARE ASSOCIATES LLC

PERMISSION TO RELEASE MEDICAL INFORMATION

I, ____ authorize
(Print Patient Name)

Regional Cancer Care Associates staff and physicians to release medical information (such as test results, plan of treatment, etc.) to the following people:

Name **Relationship**

1) ____

2) ____

3) ____

4) ____

5) ____

Please list the physicians you would like your consultation notes forwarded to:

Name	Address/Phone
____________________	____
____________________	____
____________________	____
____________________	____

Patient Signature: ________________________________

Date: ____________________________