

Hematology Oncology Associates, P.C.

Physicians & Surgeons

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AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

ACCOUNT NUMBER: _____ PATIENT NAME: _____

PHYSICIAN'S NAME: _____

By signing below, I authorize ***Hematology Oncology Associates*** to use and/or disclose my medical information to the person(s) listed below:

By: _____ Date: _____
Patient

By: _____ Date: _____
Patient Representative

Yes, I would like to give my consent to disclose my health information to specific family members or friends.

Please list the names of those you would like us to have on file:

Spouse/Partner: _____

Children: _____

Other: _____