HEMATOLOGY & ONCOLOGY CONSULTANTS OF PENNSYLVANIA, P.C.
101 ERFORD ROAD
Camp Hill, PA 17011
717-975-8900

CONSENT TO RELEASE INFORMATION

PLEASE COMPLETE ONE OF THE THREE OPTIONS LISTED:

1. ☐ DO NOT DISCUSS MY MEDICAL CONDITION WITH ANYONE.
2. ☐ NO RESTICTIONS (MAY DISCUSS WITH ANYONE).
3. ☐ I,___________________________, GIVE THE PHYSICIANS AND OFFICE STAFF PERMISSION TO DISCUSS MY MEDICAL CONDITION WITH THE FOLLOWING INDIVDIUALS:

NAME: ____________________________________ RELATIONSHIP ___________________

PHONE NUMBER: __________________________

NAME: ____________________________________ RELATIONSHIP ___________________

PHONE NUMBER: __________________________

NAME: ____________________________________ RELATIONSHIP ___________________

PHONE NUMBER: __________________________

NAME: ____________________________________ RELATIONSHIP ___________________

PHONE NUMBER: __________________________

THIS CONSENT IS IN FORCE INDEFINITELY. YOU MAY REVOKE OR CHANGE THIS CONSENT IN WRITINIG.

____________________________________ ___________________
(PATIENT SIGNATURE) *(DATE)*

____________________________________ ___________________
(PATIENT SIGNATURE) *(DATE)*