**HEMATOLOGY & ONCOLOGY CONSULTANTS OF PENNSYLVANIA, P.C.**
**101 Erford Road, Suite 101**
**Camp Hill, PA 17011**
**Phone (717) 975-8900 Fax (717) 975-9400**

## CONSENT TO RELEASE INFORMATION TO FAMILY MEMBERS AND/OR FRIENDS

**With the increasing awareness of a patient's right to confidentiality, we are asking all of our patients to complete this form. It will give the doctors and staff guidance as to who should be allowed to receive information about your healthcare and medical condition.**

PLEASE COMPLETE **ONE** OF THE THREE OPTIONS LISTED.

1. ☐ **Do NOT discuss my medical condition with anyone.**
   If you choose this option, do **not** fill out any further information. Please sign and date at the bottom.

2. ☐ **NO restrictions. You MAY discuss my medical condition and treatment with anyone.**
   If you choose this option, do **not** fill out any further information. Please sign and date at the bottom.

3. ☐ **I,_____, give the physicians and staff of Hematology & Oncology Consultants of Pennsylvania, P.C. permission to discuss my medical condition with the following individuals:**

NAME: _____

WHO IS_____ Phone #:_____
(RELATIONSHIP)

NAME: _____

WHO IS_____ Phone #:_____
(RELATIONSHIP)

NAME: _____

WHO IS_____ Phone #:_____
(RELATIONSHIP)

NAME: _____

WHO IS_____ Phone #:_____
(RELATIONSHIP)

**THIS CONSENT IS IN FORCE INDEFINITELY UNLESS YOU FILL IN AN EXPIRATION DATE OR YOU REVOKE THIS CONSENT IN WRITING.**

_____ _____
PATIENT SIGNATURE SIGNATURE / DATE

_____ _____
WITNESS SIGNATURE SIGNATURE / DATE

CONSENT EXPIRATION DATE (if any)_____

REVISED 1/2016