SHENANDOAH ONCOLOGY
Specializing in Cancer Care & Diseases of the Blood

AUTHORIZATION FOR RELEASE OF RECORDS TO SHENANDOAH ONCOLOGY, P.C.

Date: _____

I hereby authorize Dr. _____ to release the records of:
(leave blank)

_____	_____
Patient Name	Street Address
_____	_____
City, State, Zip Code	Telephone Number
_____	_____
Date of Birth	Signature

I authorize that the following records may be sent:

- ☐ Physician notes/letters
- ☐ Hospital records
- ☐ Treatment records
- ☐ Laboratory and pathology results
- ☐ Pathology slides & tissue blocks
- ☐ Radiology reports and disks
- ☐ All of the above