AUTHORIZATION OF RELEASE OF MEDICAL INFORMATION

Date: ___________________________

I hereby authorize Shenandoah Oncology, P.C. to release information from the records of:

____ ____________________________________
Patient Name | Street Address

____ ____________________________________
City, State, Zip Code | Phone Number

____
Date of Birth

____
Signature of Patient

You may release this information to the following individuals:

____ _____________________________________
Name & Relationship | Phone Number

____ _____________________________________
Name & Relationship | Phone Number

____ _____________________________________
Name & Relationship | Phone Number

____ _____________________________________
Name & Relationship | Phone Number

____ _____________________________________
Name & Relationship | Phone Number