SHENANDOAH ONCOLOGY
Specializing in Cancer Care & Diseases of the Blood

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

Medical Records Phone: 540-450-0682
Medical Records Fax: 540-667-3408

Date: _____

I hereby authorize Dr. _____to release information from the records of:
(Leave Blank)

_____ _____
Patient Name Street Address

_____ _____
City, State, Zip Code Telephone Number

_____ _____
Date of Birth Signature of Patient

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