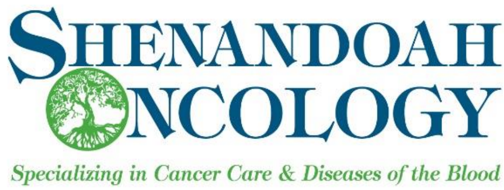

AUTHORIZATION FOR RELEASE OF RECORDS TO SHENANDOAH ONCOLOGY, P.C.

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

Date: ___________________________________

I hereby authorize Dr. ______________________to release information from the records of:

____ __________________________________
Patient Name Date of Birth

____ __________________________________
Street Address City, State, Zip Code

____
Phone Number

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

This authorization will expire in twelve months following the date of signature, unless otherwise specified below.

Expiration Date:____

Patient Signature:______________________________ Date:______________________