SHENANDOAH ONCOLOGY
Specializing in Cancer Care & Diseases of the Blood

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