Hematology Oncology
associates pc
physicians and surgeons

we're in this together

Authorization TO DISCUSS HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Account Number: _____ Physician: _____

By signing below, I authorize Hematology Oncology Associates to discuss my medical information with the person(s) listed below:

By: _____ Date: _____
PATIENT

By: _____ Date: _____
PATIENT REPRESENTATIVE

Yes, I would like to give my consent to discuss my health information to specific family members or friends.

Please list the names of those you would like us to have on file:

❑ Spouse/Partner: _____

❑ Children: _____

❑ Other: _____

❑ Other: _____

BARNETT OFFICE | 2828 E. BARNETT ROAD | MEDFORD, OR 97504
PROVIDENCE CANCER CENTER | 940 ROYAL AVENUE, SUITE 100 | MEDFORD, OR 97504
THREE RIVERS MEDICAL PLAZA | 520 S.W. RAMSEY AVENUE, SUITE 201 | GRANTS PASS, OR 97527
WEB | WWW.HEMONCASSOC.COM

PHONE | 541-774-5853
TOLL FREE | 888-774-4911
FAX | 541-608-6632
MEDICAL RECORDS FAX | 541-608-6674

TEK 435 - REV 02-2011