ALABAMA ONCOLOGY

PATIENT CONFIDENTIALITY RELEASE FORM

Patient Name: _____

Due to patient confidentiality issues, it is necessary that we have your permission to release any information regarding your office visits, or any other information pertaining to your healthcare. Please list below any family members you give us permission to discuss your medical care with.

Name: _____ Phone:_____

Name: _____ Phone:_____

Name: _____ Phone:_____

Name: _____ Phone:_____

Patient's Signature: _____