Northwest Oncology, PC
1001 Calumet Ave., Dyer, IN 46311
1600 S. Lake Park Ave., Ste. 1101,
Hobart, IN 46423

Authorization to Release Medical Information

Patient Name_________________________________ Soc. Sec. #________________________

Address _____________________________________ Date of Birth______________________

_____________________________________ Phone Number____________________

I hereby Authorize and request you release information from my medical record to:

□ **Dr. Mohamad Kassar** □ **Dr. Michael Tallarico**

□ **Dr. Barbara Fuller** □ **Dr. Amer Sidani**

□ **Dr. Neel Shah** □ **Dr. Sania Raza**

The Information to be released is from the time period From:______/_______/ _______

To:______/________/________

HOSPITALIZATION

_______ Discharge Summary

_______ History and Physical

_______Consultation

_______ Other (Specify)

OUTPATIENT VISITS

_______Medical Summary

_______History and Physical

_______Consultation

_______Lab Reports

_______ Diagnostic Reports

_______Chemo Orders / Flowsheets

The complete history of record in your possession concerning my illness and/or treatment for the above –mention dates.
I understand that the consent is revocable by me, in writing, at any time except to the extent the action has taken place in reliance on it. I also understand that this consent will expire either 60 days after the date of the signature or automatically when the records requested by this authorization have been sent to the requestor.

Signature_________________________________ **Date**_______________