

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. Sameer Sharma**

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 _____