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CONSENT TO OBTAIN MEDICAL INFORMATION

Patient Name: _____ DOB: _____

SSN: _____ Phone #: _____

Information to be released to: **Blue Ridge Cancer Care.**

Please fax information to: _____ Attn: _____

Information to be released:

____ Clinical Progress Notes ____ Lab Reports ____ CT Scans
____ Pathology Reports ____ All Hospitalization Records ____ Radiology Reports
____ Other (specify) _____

- I understand that information to be released may include information regarding drug abuse, alcohol abuse, psychological or psychiatric impairments, HIV and/or AIDS or physical conditions. If information pertaining to drug or alcohol abuse or treatment of the same has been disclosed, it has been done so from records protected by Federal confidentiality rules (45CFR Part 2). The Federal rules prohibit BRCC from making any further disclosure of this information unless further disclosure is expressly permitted by the patient.
- I understand I may revoke this authorization at any time, except to the extent that action has already been taken. If not previously revoked, this consent will expire one year from date of signature.

Signature of Patient **Date**

Signature of Guardian/Representative

Signature of Witness **Date**

Relationship

Expiration Date

Caring For Patients With Cancer And Blood Disorders For More Than 30 Years.

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