

Notification of Disclosure to Persons Involved in Your Case



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|--------------|------|---------------|-----|
| Patient Name | | Date of Birth | Age |
| Street | City | State/Zip | |

Unless you specifically agree, we will not disclose any information to family or other persons involved in your care either by phone or in person. This means, for example, that we will not be able to answer questions about your radiation treatments, medications, prescriptions, billing, schedule appointments or otherwise discuss any aspect of your care or treatment with anyone other than you.

If you would like us to be able to discuss information related to your care with specific persons, please list those persons below.

| Name | Relationship to Patient |
|------|-------------------------|
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Patient Comments: _____

I hereby authorize Peninsula Radiation Oncology Center to discuss all aspects of my treatments with the above listed persons.

Patient Signature

Date

Witness Signature

Date

Patient Name: {Patient.NameLFM}

MR #: {Ident.IDA}

Date of Birth: {Admin.Birth_Date@d18b}
