THE CENTER FOR CANCER AND BLOOD DISORDERS

6410 Rockledge Dr, Suite 660 Bethesda, MD 20817
19735 Germantown Rd, Suite 255
Germantown, MD 20874
Phone (301) 571-0019
Fax (301) 571-0988

Authorization for Medical Record Disclosure/Use of Protected Health Information

I, _____, do hereby authorize

_____ to provide in writing to the Center for Cancer and Blood Disorders a report of my diagnosis, treatment, prognosis, and recommendations as well as other data pertinent to his/her treatment of me during the time I was under his/her care.

_____ _____

Witness

Patient's Signature

_____

Patient's Name

_____

Date

_____

Date of Birth

_____

Social Security Number