



**RADIATION ONCOLOGY
RELEASE OF INFORMATION CONSENT**

I choose to allow the Radiation Oncology staff permission to be able to discuss me or my treatment with the individuals listed below.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

I choose not to allow the Radiation Oncology staff permission to discuss me or my treatment with anyone.

I give permission to be contacted and/or receive test results, appointments, prescription information at:

Home Ph# _____ Best time to call _____

Work Ph# _____ Extension _____

Via cell phone.....Cell # _____

Via messages on answering machine.

Emergency

Contact _____

Address & Phone _____

I fully understand and agree to the choice indicated above.

Signature

Relation if other than patient

Witness

Date

