

**NORTH SHORE ONCOLOGY -
HEMATOLOGY ASSOCIATES LTD.**

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name : _____ ***Birth Date :*** _____

I, the undersigned, authorize you to furnish a copy of or to allow the following medical records to be inspected/reviewed:

- | | |
|------------------------------------|---|
| ____ Laboratory Data | ____ Medication Records / Flow Sheets |
| ____ Radiology Reports | ____ Immunization Records |
| ____ Progress / Doctors notes | ____ Hospital Notes |
| ____ Pathology Reports | ____ Operative report(s), findings, and complications |
| ____ All other pertinent documents | |

I authorize the release of medicals records to and/or from:

- North Shore Oncology-Hematology Associates, LTD.
- All physicians, health care facilities, and diagnostic centers involved in the course of my treatment

I specifically consent to the disclosure of records that may contain alcohol / drug or substance abuse information.

I specifically consent to the disclosure of records that may contain HIV results or diagnosis and AIDS and AIDS-related conditions.

I specifically consent to the disclosure of records that may contain mental health information.

If not previously revoked in writing, this authorization will expire TWELVE (12) months from the date of my signature.

Signature of Patient or Authorized Legal Representative

Date