Oregon Oncology
Specialists

Authorization for Release of Information

I, ____ (DOB____/____/____)

I give my consent and or authorization to **Oregon Oncology Specialists, LLP** to discuss my medical condition, confirm appointment times, release records, pick up prescriptions, update address and phone number, and/or discuss financial information to the following family and friends:

(It is not necessary to include ANY physicians on this form)

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This consent/authorization will remain in effect unless I revoke it.

____ ________________
Signature Date