CANCER CENTER
AT GAITHERSBURG

To Whom It May Concern:

I, _____, hereby authorize Cancer Center at
(Patient Name)

Fairfax/Cancer Center at Gaithersburg to release any information regarding my medical history, treatment, and/or billing information to the following:

_____ (Relationship) _____

_____ (Relationship) _____

_____ (Relationship) _____

_____ (Relationship) _____

_____ (Relationship) _____

_____ (Relationship) _____

I understand that I have the right to inspect and receive a copy of the information to be disclosed, and I may revoke this authorization at any time in writing, except to the extent that action has been taken base on this authorization.

_____ _____
Patient/Responsible Party Signature Date