

Tower Hematology Oncology Medical Group
9090 Wilshire Blvd
Suite 200
Beverly Hills, California 90211
(310) 888-8680
(310) 888-1886 (FAX)

**CONSENT TO USE OR DISCLOSE
HEALTH INFORMATION**

I authorize **Tower Hematology Oncology Medical Group (THOMG)** to use and disclose my health and medical information as indicated below:

I authorize THOMG (check *all* that apply):

- Copy of medical record
- Discuss my health and medical information with _____(name)
- Other: _____

Exceptions/exclusions (information not to be released):

- None
- Other: _____

To or with: _____ (name/institution)

Address: _____

Attention: _____

Phone #: _____

FAX #: _____

Other Instructions: _____

I understand that I have the right to revoke this consent provided that I do so in writing, except to the extent that Tower Hematology Oncology Medical Group has already used or disclosed the information in reliance on this consent.

Signature of Patient

Date

Printed Name of Patient

Date of Birth