

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

**CONSENT TO DISCLOSE/RELEASE
HEALTH INFORMATION TO
TOWER HEMATOLOGY ONCOLOGY MEDICAL GROUP**

RELEASE OF HEALTH INFORMATION FROM:

From: _____ (name/institution)

Address: _____

Attention: _____

Phone #: _____

FAX #: _____

Other Instructions: _____

RELEASE HEALTH INFORMATION TO:

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

AUTHORIZATION:

I authorize **Tower Hematology Oncology Medical Group (THOMG)** to obtain copies of my health and medical information pertaining to my medical history including physician/provider, pathology, laboratory, imaging, operative and other diagnostic and treatment notes and reports as well as diagnostic/pathologic films and slides with the following exceptions and/or exclusions:

- None
- Other: _____

I understand that the health care information will be used for further treatment and evaluation purposes.

Signature of Patient

Date

Printed Name of Patient

Date of Birth

Social Security Number

Date(s) of Treatment