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