Notification of Disclosure to Persons Involved in Your Case

Patient Name		Date of Birth	Age
Street	City	State/Zip	

Unless you specifically agree, we will not disclose any information to family or other persons involved in your care either by phone or in person. This means, for example, that we will not be able to answer questions about your radiation treatments, medications, prescriptions, billing, schedule appointments or otherwise discuss any aspect of your care or treatment with anyone other than you.

If you would like us to be able to discuss information related to your care with specific persons, please list those persons below.

Name	Relationship to Patient

Patient Comments:_____

_____

I hereby authorize Peninsula Radiation Oncology Center to discuss all aspects of my treatments with the above listed persons.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date