

MEDICAL INFORMATION CONSENT



2200 W 1st STREET
SANFORD, FL 32771
407-321-3040 (PHONE)
407-321-3041 (FAX)
www.cancercarecenter.md

DATE: _____ / _____ / _____

I, _____, Authorize Radiation Oncology Consultants, P.A. to
() obtain () release complete medical information, including information of a psychological,
psychiatric, alcohol, drug related, HIV testing, AIDS, or AIDS related nature.

Name of Patient: _____
SS# _____ DOB: _____
Address: _____

Dates of Hospitalization: _____

Medical information to be () obtained from / () released to:

Nature of Information () requested / () released:

Date of Signature

Signature

Relationship to the patient
*If patient is a minor, mentally incompetent, or
deceased- next of kin, legal guardian, or executor of the
estate may sign.

Witness, where applicable