Central Florida CANCER CARE CENTER
Radiation Oncology Consultants, P.A.

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Steven G. Lester, MD, FACRO
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MEDICAL INFORMATION CONSENT

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/Client: _____

SS#: _____ DOB:_____

Address: _____

City: _____ State: _____ Zip: _____

Date(s) of Hospitalization: _____

Medical Information to be ( ) obtained from/ ( ) released to: _____

_____

_____

Name of Information ( ) requested / ( ) released: _____

_____

_____ _____
Date of Signature Signature

_____ _____
Relationship to the Patient Witness, Where Applicable
*if patient is a minor, mentally incompetent, or deceased-next of kin, legal guardian, or executor of the estate may sign.