RADIATION CENTER OF GREATER NASHUA

ONCOLOGY

# AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize:

| |
|---|
| Name of Institution/Physician: |
| Address: |
| Telephone: |
| Department: |

To release my medical records and/or films to:

Radiation Center of Greater Nashua
11 North Southwood Drive
Nashua, NH 03063
(603) 880-1590 phone
(603) 880-1598 fax

For the purposes of treatment, payment, and healthcare operations in accordance with the federal HIPAA Privacy Rule regulations as of April 14, 2003.

| | |
|---|---|
| Patient Name: | DOB: |
| Signature: | Date: |

If signed by Legal Representative, please indicate your name and relationship to the patient below:

| |
|---|
| Your Name: |
| Relationship to Patient: |

(parent, guardian, Medical Power of Attorney, etc.):