EAST CENTRAL ONCOLOGY ASSOCIATES
4011 Orchard Dr – Suite 1000
Midland, Michigan 48640
Phone 989-631-3975 – Fax 989-631-4844

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION AND RELEASE OF RADIOLOGY FILMS FROM _____

_____ to _____

I,_____, hereby allow:
Patient Signature

_____ _____
Name/Relationship **Name/Relationship**

Access to my medical information (to pickup my records and films, discuss my test results, or receive scheduled information on tests ordered, on my behalf, with East Central Oncology Associates, pursuant to HIPPA Privacy Regulations.

This authorization is particularly helpful for very ill patients who are not ambulatory or the elderly patients whose family members (spouse or children) assist in their medical care.