

**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.**