AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

To:_____ At:_____

From Radiation Oncology @ Capital Health Medical Center - Hopewell
One Capital Way
Pennington, NJ 08534 Telephone (609)303-4244 Fax (609)303-4156

Regarding_____Date of Birth_____

To Whom It May Concern:

The above named patient has been referred to the Department of Radiation Oncology at CHS-Hopewell Campus. In order to fully assess this patient's medical condition and the options for treatment the records listed below are necessary:

Reports:
CT SCANS_____ MRI_____ NUCLEAR MED._____
Films on above:_____ _____ _____

OTHER STUDIES_____

MEDICAL RECORDS:
PATHOLOGY REPORTS_____ PATHOLOGY SLIDES_____
OPERATIVE REPORTS_____ DISCHARGE SUMMARY_____
HISTORY & PHYSICAL_____ CHEMO RECORDS_____
CONSULTATIONS_____ LAB STUDIES_____

Your prompt attention to this request is greatly appreciated by both the patient and the consulting physician and will ensure that this patient can be seen and evaluated as soon as possible.

RELEASE OF MEDICAL INFORMATION

I authorize the release of the above requested information to the requesting radiation oncologist so that I can be seen in consultation as soon as possible.
Dr. Shirnett Williamson_____ Dr. Timothy Chen_____

Patient Signature_____Witness_____
(Or Guardian)
Date_____