

**FOX CHASE CANCER CENTER (fax completed form to: 215-728-4766, Referral Coordinator)
333 Cottman Avenue
Philadelphia, Pa. 19111**

AUTHORIZATION FOR RELEASE OF INFORMATION

This authorizes the FOX CHASE CANCER CENTER to disclose information regarding the following patient to the requestor indicated below:

PATIENT'S NAME: _____

PATIENT'S RECORD NUMBER (if known): _____ DOB: _____

REQUESTOR'S NAME: _____
(Person to whom the information is to be sent)

REQUESTOR'S ADDRESS: _____

REQUESTOR'S PHONE #: _____ FAX #: _____

DOCUMENTS TO BE DISCLOSED: _____

PURPOSE OF DISCLOSURE: _____

RECORDS NEEDED BY (date): _____

I understand that this information, except for action already taken, is subject to revocation by me at any time. In the absence of my prior revocation, this authorization will automatically expire within 60 days.

PATIENT'S SIGNATURE: _____ DATE: _____

If the patient is incapacitated or underage and cannot sign the authorization, the patient's legal guardian may sign in lieu of the patient with proof of the guardianship. If the patient has expired, the executor of the estate may sign with substantiating documentation.

PERSON AUTHORIZED IN LIEU OF PATIENT: _____

INDIVIDUAL'S RELATIONSHIP TO PATIENT: _____

DATE OF SIGNATURE _____ WITNESS' SIGNATURE _____

----FCCC Use Only----

NAME OF PERSON COMPLETING FORM: _____ EXT: _____