AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize (Facility) _____

_____

_____

to release protected health information from my medical records:

Name: _____DOB: _____

Address: _____

SSN: _____

Regarding treatment obtained: From: _____ to _____

Specific records include: □ H&P □ Clinical Notes □ Treatment Summary

□ RT films/ DRRs □ Dosimetry Plans

This information is to be disclosed to:
Sibley Memorial Hospital
Radiation Oncology Department
5255 Loughboro Road, NW
Washington, D.C. 20016

Released to the following Physician:
□ Dr. Victoria Croog □ Dr. Smitha Gollamudi □ Dr. Gregory Sibley

The information is to be released for the purpose of continuing care and quality improvement efforts.

I understand that this permission may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization.

I understand that this disclosure is voluntary on my part.

_____ _____
Signature of Patient Date