MEDICAL ONCOLOGY/
HEMATOLOGY
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Jerome H. Goldschmidt, M.D.
Lowell F. Inhorn, M.D.
Mark D. Kochenderfer, M.D.
Padmaja V. Mallidi, M.D.
Harry E. McCoy, M.D.
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Stephen H. Rosenoff, M.D., F.A.C.P.
Robert M. Rotche, M.D., F.A.C.P.
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Robert C. Heath, M.D.
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(540) 981-7377 Radiation

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2955 Market Street, Suite 5
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2400 Lee Highway
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WYTHEVILLE
590 West Ridge Road, Suite L
Wytheville, VA 24382
(276) 228-7665

BUSINESS OFFICE
(800) 998-3450
(757) 213-5701 Fax

BLUE RIDGE CANCER CARE

CONSENT TO OBTAIN MEDICAL INFORMATION

Patient Name: _____ DOB: _____

SSN: _____ Phone #: _____

Information to be released to:
Blue Ridge Cancer Care
2013 S. Jefferson Street
Roanoke, VA. 24014

Please FAX information to: _____ **Attn:** _____

Information to be released:

☐ Clinical Progress Notes ☐ Lab Reports ☐ CT Scans

☐ Pathology Reports ☐ All Hospitalization Records ☐ Radiology Reports

☐ Other: _____

- I understand that information to be released may include information regarding drug abuse, alcohol abuse, psychological or psychiatric impairments, HIV and/or AIDS or physical conditions. If information pertaining to drug or alcohol abuse or treatment of the same has been disclosed, it has been done so from records protected by Federal confidentiality rules (45CFR Part 2). The Federal rules prohibit BRCC from making any further disclosure of this information unless further disclosure is expressly permitted by the patient.

- I understand I may revoke this authorization at any time, except to the extent that action has already been taken. If not previously revoked, this consent will expire one year from date of signature.

_____ _____
Signature of Patient **Date**

_____ _____
Signature of Guardian/Representative **Date**

_____ _____
Signature of Witness **Date**

_____
Expiration Date