Methodist
RICHARDSON HEMATOLOGY
ONCOLOGY ASSOCIATES
2805 E. President George Bush Turnpike
Richardson, TX 75082

In order to better protect your privacy under HIPAA, we have created this consent form for releasing information to family members and/or other persons of the patient's choosing. This will also be used for consent to leave telephone messages at the selected phone numbers. Many times we have patients whose family members call requesting medical information and legally we are not allowed to release that information without the patient's written consent. Please take a moment to fill out this form, and we will keep it on file in your chart. It will be in effect until such notice is given in writing stating otherwise.

Please Print:

I, _____, date of birth _____ /_____ /_____, hereby give my consent for release of information contained within my medical records. This may include appointment, medical diagnosis and/or treatment to the following person(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Okay to leave messages at the following number(s):

☐ Home (_____) _____–_____ ☐ Work (_____) _____–_____

☐ Cell (_____) _____–_____ ☐ Other (_____) _____–_____

Results and/or other correspondence from my physician's office can be mailed to:

☐ Home: ☐ Yes ☐ No

☐ Email: ☐ Yes ☐ No

If yes, provide email address: _____

Signature: _____ Date: _____

Witness: _____ Date: _____