REGIONAL HEMATOLOGY ONCOLOGY ASSOCIATES

CONFIDENTIAL COMMUNICATION LIST

Patient's Name: _____

Date of Birth: _____

I give my permission for the following person/persons to inquire and receive medical updates regarding my protected health information and billing information.

PRIMARY CONTACT: _____

Phone#:_____

Relationship:_____

SECONDARY CONTACT: _____

Phone#:_____

Relationship: _____

EMERGENCY CONTACT : _____

Phone#:_____

Relationship: _____

In addition, please indicate whether we have your permission to leave any type of information regarding your condition or any test results on an answering machine Yes_____ No_____

Patient Signature: _____ Date:_____

Patient Representative: _____ Date: _____