HOAA

HEMATOLOGY & ONCOLOGY
ASSOCIATES OF ALABAMA, LLC

PATIENT CONFIDENTIALITY RELEASE FORM

PATIENT NAME: _____ **DATE OF BIRTH:** _____

PATIENT PHONE NUMBER: _____

Due to patient confidentiality issues, it is necessary that we have your permission to disclose your health information regarding your medical visits plus any additional information pertaining to your healthcare.

Please list below any family members and /or friends you authorize us to discuss your medical care with:

1. NAME: _____ PHONE: _____
   RELATIONSHIP: _____

2. NAME: _____ PHONE: _____
   RELATIONSHIP: _____

3. NAME: _____ PHONE: _____
   RELATIONSHIP: _____

PATIENT SIGNATURE: _____ DATE: _____

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Serving patients in Birmingham, Fultondale, and Gadsden