



**MEDICAL RECORD RELEASE AUTHORIZATION TO DESIGNATED PERSON**

PATIENT NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

MEDICAL RECORD NUMBER \_\_\_\_\_

I \_\_\_\_\_  
(patient name)

Authorize CORNWALL RADIATION ONCOLOGY to release my medical records to

\_\_\_\_\_  
(designated individual)

I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization it must be in writing.

I understand that if I revoke this authorization it will not apply to information previously released.

I further understand that any disclosure carries with it the potential for unauthorized disclosure.

Signature of Patient \_\_\_\_\_

Witness Signature \_\_\_\_\_

Date \_\_\_\_\_