CHESAPEAKE ONCOLOGY AND HEMATOLOGY ASSOCIATES
1630 MAIN STREET
SUITE 204
CHESTER, MD 21619
(410)-643-3676 OFFICE●(410)-643-4070 FAX

DATE:_____

I hereby authorize you to release my complete medical record in your possession to:

_____

_____

_____

Concerning my illness and/or treatment during the period from:

_____

_____

_____

Patient name:_____

Address:_____

_____

Date of birth:_____

Patient Signature:_____

Witness:_____