SIERRA HEMATOLOGY & ONCOLOGY

Medical Center, a Professional Corporation

Name _____ **Date** _____

DOB _____ **Social Security No** _____

Information requested from:

_____

I hereby authorize the release of my medical information to:

☐ Gregory Blair M.D.
☐ Grigorios Chrysofakis, M.D.
☐ John Kailath M.D.
☐ Ram Lalchandani M.D.
☐ Babak Rajabi M.D.
☐ Navneet Virk M.D.

Unless specified below, this release is to cover ALL of my medical information as needed for further evaluation and care under the above listed Hematology & Oncology physician.

_____

_____

Unless otherwise noted, HIV records are not to be released under this medical records release.

This authorization can be revoked by the undersigned grantor at any time. If not revoked, it shall terminate at the end of 12 months.

_____ _____

Patient Signature **Witness**