ALLIANCE
Cancer Specialists

CONFIDENTIAL COMMUNICATIONS REQUEST

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. (This may be a relative or friend).

Name_____
Phone #:_____
Relationship_____

Name_____
Phone #:_____
Relationship_____

Name_____
Phone #:_____
Relationship_____

Name_____
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 _____

Relationship to patient (if signed by personal representative of patient)

_____