ALLIANCE
Cancer Specialists

Confidential Communication 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).

Please print the following information.

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 or voicemail. ☐Yes ☐ No

Patient or Representative Signature_____ Date _____

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