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## MEDICAL INFORMATION RELEASE TO FAMILY / FRIENDS

**PATIENT'S NAME:** \_\_\_\_\_

To maintain Privacy, Confidentiality and Protection of health information and to comply with the Federal H.I.P.A.A. law, I give my permission to Inland Hematology Oncology Medical Group's physicians and employees to release my personal information to my spouse and/or spokesperson for family and friends to:

NAME	RELATIONSHIP	INITIAL & DATE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient's signature \_\_\_\_\_ Date: \_\_\_\_\_