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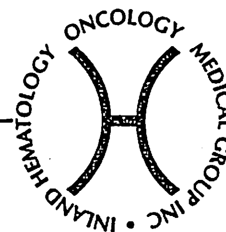
Established 1978



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MEDICAL INFORMATION RELEASE TO FAMILY / FRIENDS

PATIENT'S NAME: ____

To maintain Privacy, Confidentially 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
____________________	________________	_______________
____________________	________________	_______________
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Patient's signature________________________________Date:___________