REGIONAL
MEDICAL ONCOLOGY CENTER

# MEDICAL RECORD RELEASE

Date: _____

Patient Name: _____ Date of Birth: _____

Address: _____

Home Phone: _____ Cell/Work Phone: _____

***I hereby authorize the release of my medical records from:***

Name of Practice: _____

Address: _____

City/State/Zip Code: _____

Phone: _____ Fax: _____

☐ Regional Medical Oncology Center
2624 Ortho Drive
Wilson, NC 27893

***Please send the following:***

☐ Office Visit Notes ☐ Labs ☐ CT / Xrays ☐ Other: _____

**SEND RECORDS TO:**

☐ Regional Medical Oncology Center
2624 Ortho Drive
Wilson, NC 27893

☐ Patient

☐ Name of Practice: _____

Address: _____

City/State/Zip Code: _____

Phone: _____ Fax: _____

**Patient or guardian's signature:** _____