Atlanta Cancer Care

AFFILIATED WITH

NORTHSIDE HOSPITAL CANCER INSTITUTE

BEAT CANCER

HIPAA RELEASE

I _____, hereby do give permission to Atlanta Cancer Care to discuss my medical case with the following persons:

Name: _____ Phone Number: _____ Relationship: _____

Name: _____ Phone Number: _____ Relationship: _____

Name: _____ Phone Number: _____ Relationship: _____

Name: _____ Phone Number: _____ Relationship: _____

The following are persons whom I specificially DO NOT wish my case to be discussed with:

Name: _____ Phone Number: _____ Relationship: _____

Name: _____ Phone Number: _____ Relationship: _____

Name: _____ Phone Number: _____ Relationship: _____

Name: _____ Phone Number: _____ Relationship: _____

PATIENT SIGNATURE : _____ DATE: _____