

Hematology/Oncology Clinic
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I _____ (Please print) give the Hematology/Oncology Clinic authorization to give my personal health information to the following individual(s) and phone numbers.

1. _____ Phone# _____

2. _____ Phone# _____

3. _____ Phone# _____

4. _____ Phone# _____

Signature _____ Date _____

Hematology / Oncology Clinic

Dr. Deborah A. Abernathy Dr. Gerald P. Miletello
Dr. Georgia A. Reine Dr. Chris McCanless
Dr. Michael J. Castine III Dr. Vince D. Cataldo

8595 Picardy Avenue Suite 400
Baton Rouge, LA 70809
Phone (225) 767-0822
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REQUEST FOR RELEASE OF MEDICAL RECORDS

FROM: _____

City _____

State _____

Zip _____

I hereby request that my records be released to:
Hematology / Oncology Clinic
8595 Picardy Avenue Suite 400
Baton Rouge, LA 70809

PLEASE PRINT

D.O.B. _____

Patient's Name: _____

Address: _____

City _____

State _____

Zip _____

Date: _____

Patient's Signature: _____

Received by: _____