HEMATOLOGY/ONCOLOGY ASSOCIATES OF CENTRAL NEW YORK, P.C.

5008 Brittonfield Parkway, East Syracuse, NY 13057
Phone 315-472-7504 Fax 315-634-5168

Contact and Medical Release Authorization Form

I, ___________________________DOB_____________________, am a patient at Hematology Oncology Associates of CNY, P.C.,

I authorize all staff to contact me by the following methods:

Home phone ________________________ Priority (1,2,3) _____ May leave a message? Yes ______ No ______

Cell phone ___________________________ Priority (1,2,3) _____ May leave a message? Yes ______ No ______

Work phone_________________________ Priority (1,2,3) _____ May leave a message? Yes ______ No ______

I authorize physicians, nurses and other health care professionals involved in my care to **verbally disclose** information regarding my care to the following **Authorized Family and Friends**

Print Name____ **Relationship**__________________________ **Phone**________________

All verbal communication to Include: ☐History including Mental Health / Alcohol/Drug Treatment ☐Billing

Print Name____ **Relationship**__________________________ **Phone**________________

All verbal communication to Include: ☐History including Mental Health / Alcohol/Drug Treatment ☐Billing

Print Name____ **Relationship**__________________________ **Phone**________________

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Print Name____ **Relationship**__________________________ **Phone**________________

All verbal communication to Include: ☐History including Mental Health / Alcohol/Drug Treatment ☐Billing

Alcohol/Drug Treatment and Mental Health treatment information will only be released to the listed individuals if the patient has chosen to disclose this information by selecting the box.

I understand that I may revoke this consent at any time, except to the extent that the disclosure has already been made. I may make additions or deletions to the form. Changes can be made by completing another form. I understand that no information will be given to any family member or caretaker who is not listed on this form.

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Patient Signature / Authorized Representative Date

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