

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I authorize the release of the following medical information to:

ADVANCED RADIATION ONCOLOGY CENTER

95 N. Greenleaf St., Suite A  
Gurnee, IL 60031  
Tel. 847/623-2114 Fax 847/623-4628

1025 Red Oak Lane, Suite 180  
Lindenhurst, IL 60046  
Tel.224/444-8390 Fax 224/444-8392

\_\_\_ Face sheet

\_\_\_ X-ray, scan, MRI reports

\_\_\_ Consultation reports

\_\_\_ Laboratory reports

\_\_\_ History & Physical

\_\_\_ Pathology reports

\_\_\_ Operative reports

\_\_\_ Tumor marker reports

\_\_\_ Radiation Therapy records

\_\_\_ Other \_\_\_\_\_

\_\_\_\_\_  
signature

\_\_\_\_\_  
date

\_\_\_\_\_  
Patient name

\_\_\_\_\_  
Date of birth

\_\_\_\_\_  
Date of treatment

\_\_\_\_\_  
Social security number

\_\_\_\_\_  
Witness

This release shall remain in effect for one year.