# ONCOLOGY ASSOCIATES OF SAN DIEGO

A MEDICAL GROUP

Dr. Robert M. Barone, M.D., F.A.C.S. Dr. Paul M. Goldfarb, M.D., F.A.C.S.

## AUTHORIZATION TO RECIEVE OR RELEASE MEDICAL RECORDS

I hereby authorize:

_____

_____

(Name and Address of Physician, Hospital or Health Care Provider)

To Furnish To:

_____

(Name of Physician)

Oncology Associates of San
Diego 3075 Health Center Dr.
Suite 102
San Diego, CA 92123
Phone (858) 637-7888 Fax (858) 637-7887

Any and all medical records and information pertaining to my medical history and/or treatment.

CONFIDENTIALITY NOTICE: THE INFORMATION CONTAINED IN THIS RELEASE IS INTENDED ONLY FOR THE USE OF THE INDIVIDAUL TO WHOM IT IS ADDRESSED AND MAY CONTAIN INFORMATION THAT IS PRIVILEGED, CONFIDENTIAL AND EXEMPT FROM DISCLOSURE UNDER APPLICABLE LAW.

_____ _____

Printed Name of Patient Signature of Patient

_____

Maiden Name/Previous Name

If signed by other than patient, indicate relationship and reason:

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