CAPITAL HEALTH MEDICAL CENTER – HOPEWELL
NEUROSURGICAL-ONCOLOGY
HIPAA CONSENT TO RELEASE MEDICAL INFORMATION
Two Capital Way, Suite 456
Pennington, NJ 08534

Arlan H. Mintz, MD Capital Institute for Neurosciences
Shirnett Williamson, MD Department of Radiation Oncology
Timothy Chen, MD Department of Radiation Oncology
Roy A. Patchell, MD

Patient Name: _____ Date: _____

DOB: _____

I. When we need to contact you regarding test results, prescription refills, rescheduling appointments, etc., please indicate where we can leave a message (circle Yes or No):

HOME NUMBER - YES / NO _____

CELL NUMBER - YES / NO _____

II. I authorize the following individuals to receive information pertaining to my medical care.

NAME	RELATIONSHIP	CONTACT NUMBERS

I agree _____ to the above. Date signed: _____
(Patient Signature)

Signing this form verifies all information is correct and/or has been updated:

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____