Solano Hematology Oncology, Inc.
100 Hospital Drive, Suite 110
Vallejo, CA 94589
Phone (707) 551-3300
Fax (707) 551-3301

Cancer Treatment Center of Vacaville
1360 Burton Drive, Suite 170
Vacaville, CA 95687
Phone (707) 446-1114
Fax (707) 446-1119

Chainarong Limvarapuss, M.D.
Walailuk Chaiyarat, M.D.
Ann M. Wexler, M.D.

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____ D.O.B.: _____

Physician or Medical Facility To Release Information:

Name: _____ Phone: _____

Address: _____ Fax: _____

I hereby authorize the above named physician or medical facility to release my complete personal health information (medical records including diagnosis, physician notes, diagnostics, films, and other information) for purposes as needed, and as allowed by law, in the treatment and/or further diagnosis of my condition or illness.

I authorize this information to be released in its entirety to:

_____ Solano Hematology Oncology and Cancer Treatment Center of Vacaville
(Initial)

c/o Medical Records Dept.
100 Hospital Dr., Ste. 110, Vallejo, CA 94589
Phone: (707) 551-3300
Fax: (707) 551-3301

and/or

_____ _____
(Initial) (Name and Address of Physician, Medical Facility, or Other Individual or Group)

This authorization is to remain in effect indefinitely, as allowed by law. I also realize that I may revoke and terminate this authorization, for any future release or disclosures of my personal health information at any time, by submitting written notice of revocation to the previously authorized individual or entities authorized.

_____ _____
(Signature of Patient, Legal Guardian, Conservator, DPA or Legal Representative) (Date)

_____ _____
(Printed Name) (Relationship to Patient)