Contra Costa Oncology

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RECORDS RELEASE AUTHORIZATION

DATE: _____

TO: _____

PHONE: _____ FAX_____

PATIENT NAME: _____ DOB_____

I AUTHORIZE MY MEDICAL RECORDS, CONCERNING MY ILLNESS AND/OR TREATMENT, TO BE SENT TO:

CONTRA COSTA ONCOLOGY
500 LENNON LANE
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PHONE: (925) 939-9610
FAX: (925) 939-9630

PATIENT SIGNATURE: _____