POTOMAC RADIATION ONCOLOGY CENTER
A SERVICE OF INOVA AND SENTARA HEALTHCARE

Release of Medical Records Authorization Form

Attention: Release of Medical Records: _____

Please release the following information to____ Dr. Susan Boylan / ____Dr. Kevin Choe

FAX TO: 703-590-3199

EXAM TYPE:	**DATE OF STUDY:**
PATHOLOGY REPORTS:	_____
OPERATIVE REPORTS:	_____
DISCHARGE SUMMARIES:	_____
RADIOLOGY REPORTS:	_____
OTHER:	_____

PLEASE PRINT THE FOLLOWING

PATIENT NAME: _____

ADDRESS: _____

DOB: _____

PATIENT'S SIGNATURE: _____

Signature of authorized person to consent for patient: _____

What is your relationship to the patient? _____