

To Whom It May Concern:

I hereby authorize you to release my records to:

Medical Oncology Hematology Consultants, P.A.  
4701 Ogletown-Stanton Road-Suite 2200  
Newark, DE 19713  
(302) 366-1700 (fax)

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness