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PATIENT NAME: _____

PLEASE SIGN FOR AUTHORIZATION/RELEASE

I HEREBY AUTHORIZE PAYMENT BE MADE DIRECTLY TO THE ABOVE NAMED PHYSICIAN OF THE MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR THE SERVICES AS DESCRIBED ON ATTACHED CLAIM.

SIGNED: _____ DATE: _____

I REALIZE THAT THIS MAY NOT REPRESENT FULL PAYMENT FOR SERVICES RENDERED TO ME AND I WILL BE RESPONSIBLE FOR ANY BALANCE IN FULL (CO-PAYS, CO-INS, DEDUCTIBLES, OUT OF POCKET AND/OR DENIAL OF COVERAGE).

SIGNED:_____ DATE:_____

I HEREBY AUTHORIZE OMID S. SHAYE, M.D., ASHKAN LASHKARI, M.D., CHRISTOPHER HO, M.D., TO RELEASE ANY MEDICAL DOCUMENTATION PERTAINING TO MY MEDICAL NEEDS/INFORMATION TO OTHER PHYSICIAN REGARDING THE COURSE OF MY TREATMENT.

SIGNED: _____DATE:_____

I HEREBY AUTHORIZE THAT I, _____HAVE RECEIVED A COPY OF THE WELLNESS ONCOLOGY HEMATOLOGY PRIVACY POLICY AS DESCRIBED IN THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 AND REGULATIONS PROMULGATED THERE UNDER, COMMONLY KNOWN AS HIPPA.

SIGNED: _____DATE:_____

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