Community Cancer Center

Due to increased healthcare rules and regulations, please list all parties involved in your care or payment of care to which we may speak to or leave a message with regarding your healthcare, appointment scheduling, and payment.

Name	Relationship	Phone

Email: _____ (for access to patient portal) ❑ No Email

May we contact you at work? ❑ Yes ❑ No

May we leave a message on your answering machine? ❑ Yes ❑ No

Period for this consent is: ❑ From _____ to _____; **or**

❑ Lifetime or until notified

By signing below, I consent to Community Cancer Center's disclosure of information about my healthcare, appointments and payment to the above-named parties.

_____ _____

Patient Signature Date