Release of Medical Records

I, _____, authorize the release my medical records to ECRost Oncology.

_____All radiographic information with images in a readable format.

_____All Medical records including consultations, reports and summaries.

_____All Billing Records and insurance documentation.

_____All Pathologic reports. Do not send slides or tissue.

Please send all documents to:
ECRost Oncology, LLC
18124 Wedge Parkway #2035
Reno, NV 89511

eric@cancerhope.com

Name:_____

Signature:_____ DOB:_____

Date:_____