RADIATION ONCOLOGY
400 CAMPUS BLVD., SUITE 110
WINCHESTER, VA 22601
Phone: 540-536-8912 Fax: 540-722-2635

I, ______________________________, give permission to the following individuals to obtain information regarding my radiation therapy treatments, follow up care and billing for my radiation treatments through Winchester Medical Center.

Name:________________________Relationship:_____________Phone:_________

Name:________________________Relationship:_____________Phone:_________

Name:________________________Relationship:_____________Phone:_________

Name:________________________Relationship:_____________Phone:_________

Name:________________________Relationship:_____________Phone:_________

Signature:____

Date:____

Witness:____