COHA | CHESAPEAKE ONCOLOGY HEMATOLOGY ASSOCIATES

Yudhishtra Markan, MD
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Release of Information

I hereby authorize release of my complete medical record in your possession to:
Chesapeake Oncology Hematology Associates (COHA).

Patient Name: _____

Date of Birth: _____

Patient Address: _____

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I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization.

Patient Signature: _____ Date: _____

Patient Representative: _____ Date: _____

Relationship to Patient: _____

For Internal Use Only

COHA Staff	**Date**
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