STOCKTON HEMATOLOGY ONCOLOGY MEDICAL GROUP, INC.

RELEASE OF MEDICAL INFORMATION

I authorize Stockton Hematology and Oncology to release medical information, including medical records and x-rays concerning my past and present medical history and condition to other physicians involved in my care. This authorization will remain in effect as long as I am a patient in this practice, or until I withdraw my authorization in writing.

Signed:_____ Date:_____