# CANCER CARE OF WESTERN NEW YORK
## Release Form

I, _____, hereby authorize you to release to:

Cancer Care of Western New York
Harlem Professional Park
3085 Harlem Road, Suite 200
Cheektowaga, NY 14225

any information including the diagnosis and records of any treatment or examination rendered to me.

Patient Signature _____ Witness _____

Date _____ Date _____

(Please print)

Name _____

Address _____

_____

Telephone _____

Date of Birth _____