LA CANCER NETWORK
Los Angeles Hematology/Oncology Medical Group
Insurance Benefits and Information Release

Name: _____ Date: _____

Address: _____ Home Tel: _____

_____ Work Tel: _____

I hereby authorize the physician to release any and all information necessary concerning my diagnosis and treatment for the purposes of securing payment from my insurance company; and thereby authorize payment of the insurance benefits directly to the physician for any services rendered that are not paid for directly by me.

_____ _____

Patient's Signature Date

(or parent or guardian's signature if patient is a child)

Please complete and sign this form and fax to (213) 482-8868 prior to your scheduled appointment.