NL **Noah Lindenberg PC**
Hematology / Oncology

773 Route 70 East, Suite E-125, Marlton NJ 08053
Phone: (856) 890-7200 Fax: (856) 872-7636

■ Patient Information

Name (Last, First, Middle) ______________________ Today's Date ______________
Birthdate ______________ Soc. Sec. # ______________ Home Phone ______________
Email address ______________________ Cell Phone ______________
Address ______________ Apt # ________ Work Phone ______________
City ______________ State ________ Zip ______________
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated Sex: ☐ M ☐ F
Race: ☐ Black / African American ☐ White / Caucasian ☐ Hawaiian / Pacific Islander ☐ American Indian ☐ Asian ☐ Unknown ☐ Other
Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Prefer not to specify
How did you hear about us? ______________________
Primary Care Physician ______________________ Phone ______________

■ Person Financially Responsible for Account *(if same as patient, write "same" on Name line.)*

Name (Last, First, Middle) ______________________ Relationship ______________
Birthdate ______________ Soc. Sec. # ______________ Home Phone ______________

■ Primary Insurance

Insurance Carrier ______________________ Policy Number ______________
Please give the receptionist your card, to scan into our files. If the patient is the policyholder, check this box ☐ and skip to the next section.
Policyholder's Name (Last, First, Middle) ______________________ Relationship ______________
Policyholder's Date of Birth ______________________ Phone ______________
Address (if different from patient) ______________________ Sex: ☐ M ☐ F
Employer's Name (if insurance is through work) ______________________

■ Secondary Insurance

Insurance Carrier ______________________ Policy Number ______________
Please give the receptionist your card, to scan into our files. If the patient is the policyholder, check this box ☐ and skip to the next section.
Policyholder's Name (Last, First, Middle) ______________________ Relationship ______________
Policyholder's Date of Birth ______________________ Phone ______________
Address (if different from patient) ______________________ Sex: ☐ M ☐ F
Employer's Name (if insurance is through work) ______________________

■ Assignment and Release

I hereby authorize payment directly to Noah Lindenberg, PC of all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered to and for me. If my insurance plan requires an authorization or referral, and I do not obtain one for the services I receive, I understand that I am responsible for all charges, even if the provisions of my plan stipulate I otherwise wouldn't be. I authorize the doctors and/or any provider or supplier of services in this office to release all information required to secure the payment of benefits, including protected health information. I authorize the use of my signature on all insurance submissions. I authorize a copy of this document to be used in place of the original. I have read and agreed to the above.

Signature: ______________________ Today's Date: ______________

Patient Name: ______________________________ Date of Birth: ______________

■ Pharmacy

Preferred Pharmacy Name ______________________ Phone ______________

Address ____

■ Review of Systems

	Yes	No
Pacemaker	☐	☐
Artificial joints within past 2 years	☐	☐
Premedication prior to procedure	☐	☐
Allergy to topical antibiotic ointments	☐	☐
Pregnancy, or pregnancy planned	☐	☐
Rapid heartbeat with Epinephrine	☐	☐
GI upset with antibiotics	☐	☐
Problems with healing	☐	☐
Wheezing	☐	☐
Immunosuppression	☐	☐
Rash	☐	☐
Anxiety	☐	☐
Blurry vision	☐	☐
Cough	☐	☐
Headaches	☐	☐
Shortness of breath	☐	☐

	Yes	No
Defibrillator	☐	☐
Artificial heart valve	☐	☐
Allergy to adhesive	☐	☐
Problems with bleeding	☐	☐
Allergy to Lidocaine	☐	☐
Yeast infections with antibiotics	☐	☐
Blood thinners	☐	☐
Problems with hypertrophy or keloids	☐	☐
Changing mole	☐	☐
Abdominal pain	☐	☐
Bloody urine	☐	☐
Chest pain	☐	☐
Fever or chills	☐	☐
Hay fever	☐	☐
Muscle weakness	☐	☐
Seizures	☐	☐
Thyroid Problem	☐	☐

■ Past Medical History *Please circle all that apply.*

Anxiety	Depression	Leukemia
Arthritis	Diabetes	Lung Cancer
Artificial joints	End Stage Renal Disease	Lymphoma
Asthma	GERD	Pacemaker
Atrial fibrillation	Hearing Loss	Prostate Cancer
BPH	Hepatitis	Radiation Treatment
Bone Marrow Transplantation	Hypertension	Seizures
Breast Cancer	HIV / AIDS	Stroke
COPD	Hypercholesterolemia	Valve Replacement
Coronary Artery Disease	Hyperthyroidism	None

Other: ____

Patient Name: ______________________ Date of Birth: ______________

Past Surgical History *Please circle all that apply.*

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
Testicle Removed (Right, Left, Bilateral)
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years

Kidney Biopsy
Kidney Removed (Right, Left, Bilateral)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
TURP
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
PTCA
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
None

Other: ______________________

Additional Questions

Please list all medications:

____
____
____

Please list all allergies:

____
____
____

Do you currently smoke or chew tobacco? Yes No
If Yes, how many per day? ______________

If No, did you smoke in the past? Yes No

Do you currently drink alcohol? Yes No
If Yes, how many drinks per day? ______________

If No, did you drink in the past? Yes N

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FINANCIAL POLICIES

Upon scheduling and registration we require you to provide your medical insurance card (if you are utilizing its coverage, it must be brought to every visit), photo identification, your address, date of birth, and phone number. If you receive health benefits through a spouse, partner or parent, we require you to provide that person's full address, date of birth, and phone number as well. For collection purposes, we require social security numbers as well. Intentionally failing to notify us of changes to your insurance coverage may constitute fraud, and we may be obliged to report such behavior.

Keeping Appointments: Should you not arrive for a scheduled office visit, unless that appointment has been cancelled at least 1 full business day in advance, you may be charged $50 for each no-show occurrence. Failure to show for a scheduled infusion may be charged a $150 no-show fee. Should you no-show twice within a 12 month period, you may be dismissed from the practice.

Medicare: If you have coverage with Medicare (including both original Medicare and commercial Medicare Advantage plans), it is your responsibility to understand the provisions of your health insurance plan and coverage. Every original Medicare beneficiary is responsible for an annual deductible and a coinsurance. Medicare Advantage beneficiaries may be responsible for an annual deductible, coinsurance and/or a copayment. Any portion of copayment, coinsurance and deductible which is not covered by a supplemental carrier will be your financial responsibility to pay. You are wholly responsible for your coverage limitation, regardless of whether you are aware of the details. If you have both Medicare coverage and also commercial insurance, you are responsible for providing the correct primary insurance at your visit. If you have supplemental insurance that does not cross over automatically, you will be billed for the deductible and coinsurance, and you may be given a receipt to submit yourself. By signing below you specifically agree to these terms, and exempt yourself from any protections your insurance plan may offer you regarding these provisions.

Commercial Health Insurance Plans: Although we will advise you whether we believe we participate with your insurance carrier, we are not responsible for any verbal assurances made to you regarding whether particular services rendered in this practice are covered by your plan. You and you alone are responsible to understand the provisions of your health insurance plan and coverage. We recommend contacting your carrier prior to receiving services in order to verify your financial responsibilities.

Tertiary Insurance: If you have more than two insurance policies in effect, we will submit claims only to the primary and secondary insurance. you will be invoiced for any remaining balance, and you may be given a receipt to submit yourself to a tertiary plan.

Referrals: You are responsible to obtain all necessary referrals prior to your appointment, if required by your health plan. We will do our best to ensure you have one if you need one, but the ultimate responsibility is yours. If your plan requires a referral or authorization that you do not obtain, and your health plan refuses to pay for any claim for lack of a referral or authorization, you explicitly agree to be responsible for our charges for any affected visits, even if the provisions of your plan stipulate you otherwise wouldn't be (you are waiving that defense). If you come to an appointment without a required referral, and you reschedule, the canceled visit is treated a no-show, as explained above in the Keeping Appointments paragraph.

Copayments: If your plan has a copayment, it is your responsibility to pay it at the time of service, even if the amount it not printed on your insurance card. Please have your payment ready upon check-in. Please be aware that, should you not pay your copayment at the time of service, you will be responsible to pay an invoice fee of $25.

Direct Patient Payment: If your insurance plan issues payment to you instead of to us, you are responsible to turn the entire payment over to us immediately upon receipt together with the complete explanation of benefits form. You may be responsible for an additional balance, depending on how your insurance plan adjudicates such a claim.

Financial Security and Collections: It is our policy to request patients to keep a credit card on file as financial security against deductibles, co-insurance and other instances of patient balances due to us as outlined in this document. You shall continue to be sent invoices in the mail. However, if you do not pay your invoices in a timely fashion, we reserve the right to add a 10% penalty for failure to pay your invoices, and charge the credit card on file for the new total amount as a stop-gap to avoid sending accounts to collections. However, if you do not pay your invoices in a timely manner, and you do not provide a credit card for our files, or the card you provide is not valid or funded when we attempt to use it, your account shall be sent to collections. In that event, you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 30% of the debt, and all costs and expenses, including reasonable attorneys' fees, which we incur in such collection efforts. You may be dismissed as a patient by our practice for failure to meet your financial obligations. Please provide your credit card security information here, and give the receptionist the card to photocopy:

Visa MC AMEX Card #: ______________________ Expiry: ________ Security #: ______ HRA or Flex Spend? Y / N

Credit card billing address: ____

Health Insurance non-payment: Services that have not been paid by your health insurance carrier within 60 days of claim submission will become your financial responsibility to pay in full. In cases of retroactive disenrollment you are responsible immediately upon notification to us by the carrier.

Self-pay patients: If you do not have health insurance, or are receiving a service known to not usually be covered, it is our policy that you must pay for your service before leaving the office. If you have insurance through an out-of-network insurance to which we do not agree to submit claims on your behalf, you must ask for a complete receipt at the time of service.

Laboratory Testing: If you are a member of an insurance plan that requires you to have your laboratory specimens sent to a particular laboratory, and this office is so informed by you, we will happily send your specimens to that laboratory, unless the provider determines that another laboratory is preferred for medical reasons. However, regardless of which laboratory patient specimens are sent to for analysis, you are entirely responsible for all charges assessed by the laboratory, and shall handle financial matters directly with the laboratory.

Credit Card Charges: If you pay for your charges with a credit card and feel the charges are either unwarranted or otherwise nor your responsibility based on the provisions of your health insurance plan, you must first contact our billing department before contacting your credit card vendor. If you contest credit card charges without first contacting us, or you contest credit card charges which your insurance carrier has applied to your financial responsibility, and those charges are reversed by the credit card vendor or merchant bank, your balance due may be immediately treated as overdue debt, a collections fee may be appended, and the entire account may be sent to our collection agency, as outlined above, in the Financial Security and Collections paragraph.

I have read, fully understand, accept and explicitly agree with all the above policies at and of Noah Lindenberg, PC. I fully understand and accept my financial responsibility for the charges I or my dependents may incur at this office. My signature also acts as authorization to use the credit card provided in this document as explained above in the Financial Security and Collections paragraph.

Patient Name (Please print clearly): ____________________________________

Signature: ______________________________ Date: ______________

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PRIVACY PRACTICES ACKNOWLEDGEMENT

♦ Noah Lindenberg, PC and its staff and providers, may use and disclose my Protected Health Information* ("PHI") to carry out treatment, payment and healthcare operations (TPO). I understand and acknowledge that Noah Lindenberg, PC's Notice of Privacy Practices has a more complete description of such uses and disclosures.

♦ I have received your Notice of Privacy Practices and/or I have been provided an opportunity to review it. I understand and acknowledge that Noah Lindenberg, PC reserves the right to revise its Notice of Privacy Practices at any time, and that a revised version of that notice may be obtained sending a written request to the Privacy Officer at the practice.

♦ I permit Noah Lindenberg, PC to leave telephone messages regarding my appointments, prescription renewals, lab results, and all other PHI, may be left for me on voicemail systems and answering machines, or given the person or persons who answer the phone, at the following telephone numbers, in addition to any other numbers provided to you by me:

(____) ____-_____ Home / Office / Cell / Other: __________

(____) ____-_____ Home / Office / Cell / Other: __________

(____) ____-_____ Home / Office / Cell / Other: __________

[If we need to contact you with lab results, please place a check mark next to the preferred contact number, if any.]

♦ I agree that my PHI may be shared with my spouse (if applicable).

♦ I agree that my PHI may be shared with my other medical providers.

♦ I agree that my PHI may be shared with the following other people:

____________________ ____________________

____________________ ____________________

♦ I understand that I can change or revoke any of the foregoing agreements, at any time, by giving written notice to Noah Lindenberg, PC to the attention of the HIPAA Compliance Officer. I understand and acknowledge that Noah Lindenberg, PC may decline to provide me with any services should I decline to sign this agreement, or should I later revoke this agreement.

♦ I agree that my PHI may be shared with my credit card vendor(s) if I contest any credit card charges, so that Noah Lindenberg, PC can submit records to support its charges.

♦ I agree that Noah Lindenberg, PC may contact me at any email addresses provided to you by me regarding both PHI and non-PHI.

**as defined in the Health Insurance Portability and Accountability Act of 1996 and its regulations, as may be amended from time-to-time ("HIPAA")*

Patient Name (Please print clearly): ____________________________

Signature: ____________________ Date: ____________

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CONTROLLED SUBSTANCES INFORMED CONSENT

Controlled prescription medications ("CPMs") are very useful, but have potential for misuse, abuse, and addiction, and are, therefore, closely controlled by the local, state, and federal government. Your provider at Noah Lindenberg PC may prescribe you CPMs, which may include narcotics, tranquilizers, or barbiturates, to relieve your pain and improve function. However, CPMs do not work the same for everyone. They may not be effective for you, or your provider may decide they are unsafe for you. If this happens, your treatment plan will be adjusted to improve your clinical outcome or reduce risks to your health. Your provider will discuss your treatment with you before prescribing you a CPM. Your provider will discuss the goals for your treatment and how much relief you may expect. Your provider will also discuss the benefits, possible side effects, and other risks of your medication, as well as alternative forms of treatment.

This form is being provided to you to help you understand the risks of treatment with CPMs, as well as your role and responsibilities with regards to your therapy.

Please read the following information in its entirety. After you read each numbered item, please initial at the bottom of this page, and sign the second page, to acknowledge that you have read and understand each item.

1. I understand that my failure to comply with any of the conditions described below may result in changes to my treatment plan, including safe discontinuation of my CPM, and/or discharge from this practice.
2. I will inform my provider at this practice of all current doctor relationships and all medications I am taking, including herbal remedies and over the counter medications.
3. I will inform my provider at this practice if I request or accept CPMs from any other physician or individual while I am receiving such medication from my provider at this practice.
4. I will notify my provider at this practice within 48 hours if emergency situations arise that require other physicians to prescribe me a CPM (such as having surgery).
5. I will refrain from the use of illicit substances while taking my CPM, as this can put me at risk for serious and sometimes fatal adverse reactions.
6. I understand that I may experience side effects from my CPM, which may include, but not be limited to, skin rash, constipation, sexual dysfunction, sleeping abnormalities, sweating, edema, respiratory depression, habituation, and impaired cognitive or motor ability.
7. I will use my medication exactly as prescribed by my provider at this practice. I understand that increasing my dose without the close supervision of my physician could lead to drug overdose causing severe sedation and respiratory depression and death. I also understand that decreasing or stopping my medication without the close supervision of my physician can lead to withdrawal. Withdrawal symptoms can include yawning, sweating, watery eyes, runny nose, anxiety, tremors, aching muscles, hot and cold flashes, "goose flesh," abdominal cramps, and diarrhea. These symptoms can occur 24-48 hours after the last dose and can last up to 3 weeks.
8. Risks of CPM use include physical dependence, tolerance, and addiction.
    a. Physical dependence is a condition in which the body adjusts to the presence of a drug, resulting in clear symptoms of withdrawal when its use stops.
    b. Tolerance means a state of adaptation in which exposure to the drug induces changes that result in a lessening of one or more of the drug's effects over time. Your my provider at this practice may have to adjust your CPM to a dose that produces maximum function and a *realistic* decrease of your pain.
    c. Addiction is characterized by behavior that includes one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and cravings. This means the drug decreases one's quality of life. Signs of addiction shall prompt my provider at this practice to adjust my treatment plan, which may include safe discontinuation of my CPM and referral for treatment at a substance use disorder facility.
9. If I have a history of alcohol or drug misuse or abuse, I must notify my provider at this practice of such history because treatment with certain CPMs for pain may increase the possibility of relapse. A history of addiction does not necessarily disqualify one for treatment of pain with CPMs, but starting or continuing a program for recovery is a necessity, and risks must be carefully managed and monitored.

Patient Initials ______

10. I will never alter my medication in any way.
11. I will not share or sell my medication to others.
12. I will safeguard my medications from loss, theft, and damage. I understand my provider at this practice may not re-prescribe or replace lost, stolen, or damaged medications.
13. I understand that I may be required, at any time, to bring my CPM medication or medication containers in for review. I must show up within 24 hours of being notified. If I do not show up or have an inaccurate pill count my CPM medications may be discontinued.
14. I understand I must be seen on a regular basis (e.g., weekly, bi-weekly, or monthly) to obtain refills.
15. I understand that my provider at this practice will generally not prescribe CPMs without an in-person visit. I understand that it is my responsibility to call and schedule an appointment at least 3 business days before I am to run out of medication. I understand that this procedure includes situations where I have had an approved increase in my medication. I understand that my provider at this practice may not refill my prescription on the same day that I call, may require an office visit before approving a refill, and may not have an appointment available at the time that I desire.
16. I will have all my CPM prescriptions filled at a single pharmacy, which I provided to this practice in my intake paperwork.
17. I understand that my provider at this practice may access my state's prescription monitoring program database to view my CPM history. I understand Noah Lindenberg PC and its agents may use this information to supplement an evaluation of my treatment, confirm my medication history, or document compliance with my treatment plan.
18. I will not consume alcohol while taking my CPM.
19. I understand that Noah Lindenberg PC reserves the right to perform or order a random urine drug test at any time. I understand this may be needed to further evaluate my medical condition and adherence to my treatment plan. If the results of a urine drug test do not reflect medicine prescribed by my provider, or if I test positive for illegal substances, I understand that my provider at this practice may adjust my treatment plan, including safe discontinuation of my CPM, discharge me from the practice, or refer me for treatment at a substance use disorder facility. Furthermore, I understand that screening may not be covered by my insurance, and I may be responsible for the charges.
20. I hereby authorize Noah Lindenberg PC and its agents to contact any health care professional, family member, pharmacy, legal authority, or regulatory agency to obtain or provide information about my care or actions if the provider feels it is necessary.
21. FEMALE PATIENTS ONLY: I acknowledge that, to the best of my knowledge, I am not pregnant at this time. I will notify my provider immediately if I become pregnant or should I begin trying to become pregnant.

I have read the information above or it has been read to me, and all my questions regarding the treatment of pain with CPMs have been answered to my satisfaction. I hereby consent to the use of CPMs in the treatment of my condition and agree to the terms of this Controlled Substances Informed Consent form.

____
Patient Name (Please print clearly)

______________________________ ______________
Signature of Patient (or Guardian) Date

____
Printed Name of Guardian (if applicable)

For provider only: I have discussed with the patient the nature, benefits, risks, and alternatives of treatment with CPMs.

______________________________ ______________
Signature of Provider Date

CHECKLIST: Review of Systems

General-
- ◻ Weight loss or gain
- ◻ Fatigue
- ◻ Fever or chills
- ◻ Weakness
- ◻ Trouble sleeping

Skin-
- ◻ Rashes
- ◻ Lumps
- ◻ Itching
- ◻ Dryness
- ◻ Color changes
- ◻ Hair and nail changes

Head-
- ◻ Headache
- ◻ Head injury
- ◻ Neck Pain

Ears-
- ◻ Decreased hearing
- ◻ Ringing in ears
- ◻ Earache
- ◻ Drainage

Eyes-
- ◻ Vision,Loss/Changes
- ◻ Glasses or contacts
- ◻ Pain
- ◻ Redness
- ◻ Blurry or double vision.
- ◻ Flashing lights
- ◻ Specks
- ◻ Glaucoma
- ◻ Cataracts
- ◻ Last eye exam

Nose-
- ◻ Stuffiness
- ◻ Discharge
- ◻ Itching
- ◻ Hay fever
- ◻ Nosebleeds
- ◻ Sinus pain

Throat-
- ◻ Bleeding
- ◻ Dentures
- ◻ Sore tongue
- ◻ Dry mouth
- ◻ Sore throat
- ◻ Hoarseness
- ◻ Thrush
- ◻ Non-healing sores

Neck-
- ◻ Lumps
- ◻ Swollen glands
- ◻ Pain
- ◻ Stiffness

Breasts-
- ◻ Lumps
- ◻ Pain
- ◻ Discharge
- ◻ Self-exams
- ◻ Breast-feeding

Respiratory-
- ◻ Cough
- ◻ Sputum
- ◻ Coughing up blood
- ◻ Shortness of breath
- ◻ Wheezing
- ◻ Painful breathing

Cardiovascular-
- ◻ Chest pain or discomfort
- ◻ Tightness
- ◻ Palpitations
- ◻ Shortness of breath with activity
- ◻ Difficulty breathing lying down
- ◻ Swelling
- ◻ Sudden awakening from sleep with shortness of breath

Gastrointestinal-
- ◻ Swallowing difficulties
- ◻ Heartburn
- ◻ Change in appetite
- ◻ Nausea
- ◻ Change in bowel habits
- ◻ Rectal bleeding
- ◻ Constipation
- ◻ Diarrhea
- ◻ Yellow eyes or skin

Urinary-
- ◻ Frequency
- ◻ Urgency
- ◻ Burning or pain
- ◻ Blood in urine
- ◻ Incontinence
- ◻ Change in urinary strength

Vascular-
- ◻ Calf pain with walking
- ◻ Leg cramping

Musculoskeletal-
- ◻ Muscle or joint pain
- ◻ Stiffness
- ◻ Back pain
- ◻ Redness of joints
- ◻ Swelling of joints
- ◻ Trauma

Neurologic-
- ◻ Dizziness
- ◻ Fainting
- ◻ Seizures
- ◻ Weakness
- ◻ Numbness
- ◻ Tingling
- ◻ Tremor

Hematologic-
- ◻ Ease of bruising
- ◻ Ease of bleeding

Endocrine-
- ◻ Heat or cold intolerance
- ◻ Sweating
- ◻ Frequent urination
- ◻ Thirst
- ◻ Change in appetite

Psychiatric-
- ◻ Nervousness
- ◻ Stress
- ◻ Depression
- ◻ Memory loss

NOAH LINDENBERG, P.C.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name:________________________________

I have been given a copy of the Notice of Privacy Practices ("Notice") for Noah Lindenberg, P.C. (the "Practice"), which describes how my health information is used and shared. I understand that the Practice has the right to change the Notice at any time. I may obtain a current copy by contacting the Privacy Officer, Cindy Lindenberg, at Office@lindenbergcancer.com or 856-890-7200.

My signature below acknowledges that I have been provided with a copy of the Practice's Notice of Privacy Practices:

______________________________	______________________________
Signature of Patient	Date
______________________________	SPOUSE/HEALTH CARE POA/LEGAL GUARDIAN
Print Name	(Please circle one if signing on behalf of the patient)

File original in patient's chart

Records Release Form

I, ______________________________ date of birth ____________________, give permission for my records to be released to the following office.

Lindenberg Cancer Center
773 Route 73 East
Suite E-125
Marlton, NJ 08053
Phone: 856-890-7200 Fax: 856-334-6038

Please release my records from ________________________________ (Institution) to the above mentioned from dates ______________________________________.

______________________________ ______________________________

(Patient Signature) (Date)