



Community Cancer Center

Place Name
Sticker Here

Roseburg Oncology, P.C.
R. Eugene Lienert, M.D.
Randy L. Moore, D.O.
Sylvia Gosline, M.D.

Due to increased healthcare rules and regulations, we must have a list of all parties you wish to have knowledge of your healthcare status. Please provide a list of all parties to whom we may speak to or leave a message with regarding your healthcare, appointment scheduling and payment information.

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

May we contact you at work? Yes No

May we leave a message on your answering machine? Yes No

Authorization period for this consent is: From _____ to _____; **or**
 Lifetime or until notified

By signing below, I authorize information about my healthcare, appointments and payment may be provided to the above-named parties.

Patient Signature

Date