



# Community Cancer Center

Place Name  
Sticker Here

**Roseburg Oncology, PC**  
Randy L. Moore, DO  
Ashley W. Jensen, MD  
Scott R. Moore, PA-C

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