

**AUTHORIZATION TO RELEASE/EXCHANGE
INFORMATION – PERSONAL CONTACTS**



Proton Therapy Center

Patient Name _____

Date of Birth _____

FOR OFFICE USE ONLY
AFFIX PATIENT LABEL HERE

I authorize IU Health Proton Therapy Center to exchange information with **family members/ persons** listed below:

Name	Relationship to Patient	Street Address City, State, Zip	Phone

Patient Signature _____

Date _____

Guardian Signature _____

Date _____

Relationship Parent Legal Guardian Court Appointed Representative Other _____

IU Health Proton Therapy Center Staff Signature _____

Date _____