

**Missouri Cancer Care P.C.**

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330 First Capitol Drive, Suite 120 St. Charles, MO 63301 (636) 947-4007  
1092 Wentzville, MO 63385 (636) 639-8600 / (800) 621-7127  
#70 Jungerman Circle, Suite 201 St. Peters, MO 63376 (636) 498-4440

Date \_\_\_\_\_

To: \_\_\_\_\_

I hereby authorize you to release to:

\_\_\_\_\_

\_\_\_\_\_

any information including the diagnosis and records of my treatment or examination rendered to me during this period.

From: \_\_\_\_\_ To: \_\_\_\_\_

Signature: \_\_\_\_\_

Witness: \_\_\_\_\_