Community Cancer Center

Roseburg Oncology, PC
Randy L. Moore, DO
Sylvia Gosline, MD

Due to increased healthcare rules and regulations, please list all parties involved in your care or payment of care to which we may speak to or leave a message with regarding your healthcare, appointment scheduling, and payment.

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

Period for this consent is: ❑ From _____ to _____; **or**

❑ Lifetime or until notified

By signing below, I consent to Community Cancer Center's disclosure of information about my healthcare, appointments and payment to the above-named parties.

_____ _____
Patient Signature Date

_____
Printed Name