



JOHN WAYNE CANCER INSTITUTE
AT ST. JOHN'S HEALTH CENTER

**LIVER AND PANCREAS CENTER
GASTROINTESTINAL SURGERY**

WHO ARE YOUR DOCTORS?

Please list your primary doctor, referring doctor and any other physicians who are caring for you. Please fill out completely so we can expedite communication with your physicians.

Name:		Specialty:	
Address:			
City:		State:	Zip:
Phone #:		Fax #:	
Name:		Specialty:	
Address:			
City:		State:	Zip:
Phone #:		Fax #:	
Name:		Specialty:	
Address:			
City:		State:	Zip:
Phone #:		Fax #:	
Name:		Specialty:	
Address:			
City:		State:	Zip:
Phone #:		Fax #:	
I hereby authorize Liver & Pancreas Center to furnish all my medical records including but not limited to consultation notes, laboratory reports and diagnostic reports to myself and the above physician, hospital or agency as requested:			
Print Name of Patient			Date of Birth
Patient's Address			
City		State	Zip Code
Date		Patient Signature	