

FORM III - PATIENT HEALTH INFORMATION RELEASE

I HEREBY AUTHORIZE:

NAME OF HOSPITAL, DOCTOR, LABORATORY OR DEPARTMENT

ADDRESS

CITY

STATE

ZIP CODE

**TO RELEASE TO: Ann K. Lanzerotti, MD, Medical Director
The Second Opinion
1200 Gough Street – Suite 500
San Francisco, CA 94109**

RECORDS AND INFORMATION OF:

PATIENT NAME

MEDICAL NUMBER

DATE OF BIRTH

ADDRESS

TELEPHONE NUMBER

INTENDED USE: CANCER CONSULTATIVE PANEL

Duration: I understand that this authorization is effective immediately and shall be valid for six months.

Right to Revoke: I understand that I may revoke this authorization in writing at any time.

Re-use: I understand that no other use will be made of this information without prior authorization from me unless such use is specifically required/permitted by law.

RECORDS TO BE RELEASED:

- MEDICAL RECORDS RELATED TO CANCER DIAGNOSIS, INCLUDING LAB REPORTS, CONSULTATIONS, OPERATIVE REPORTS AND PATIENT SUMMARIES.
- X-RAYS AND REPORTS, CT scans, MRIs and REPORTS
- NUCLEAR SCANS AND REPORTS
- PATHOLOGY SLIDES AND REPORTS

Patient signature: _____

Date: _____