

# *thesecondopinion*

*provided by the Regional Cancer Foundation*

## PATIENT HEALTH INFORMATION RELEASE FORM

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 provided by the Regional Cancer Foundation  
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 one year or until the date entered here \_\_\_\_\_

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

**Reuse:** 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 RELATING TO CANCER DIAGNOSIS, INCLUDING LABORATORY REPORTS, CONSULTATIONS, OPERATIVE REPORTS AND PATIENT SUMMARIES.
- X-RAYS AND REPORTS
- CT SCANS AND REPORTS
- PATHOLOGY SLIDES AND REPORTS
- MRIs AND REPORTS
- NUCLEAR SCANS AND REPORTS

Patient signature: \_\_\_\_\_

Date: \_\_\_\_\_

**NOTE:** Slides and radiology will be returned to the patient on the date of the consultation.