thesecondopinion

Compassion, Clarity, Choice

FORM I : REGISTRATION and AUTHORIZATION

THIS AUTHORIZATION APPLIES TO ALL MEDICAL RECORDS, MATERIALS AND INFORMATION PROVIDED TO THE SECOND OPINION

I am requesting a Second Opinion concerning my cancer diagnosis and treatment. By signing this document I am authorizing **thesecondopinion** to access my medical information and share it with physicians/medical specialists associated with **thesecondopinion** service for the purpose of providing a medical consultation to me and my treating physicians.

I understand that my records will be seen by employees of **thesecondopinion**, who will distribute them only to the physicians and medical specialists involved in providing my second opinion. All of my information will remain confidential. This authorization also applies to any updated information that I may bring to my second opinion meeting on my panel date.

I also give permission to provide a follow-up second opinion letter to myself and my treating physicians, whom I shall designate at the time of the panel session.

I understand that **thesecondopinion** charges no fees for its services but accepts tax deductible contributions as a non-profit organization.

I understand that I may revoke this authorization in writing at any time.

This authorization expires one year from the date shown below or upon my revocation, whichever occurs earliest.

Patient Signature: _____ Date: _____

Address: _____

_____

_____

Phone: _____

1200 Gough Street, Suite 500 San Francisco, CA 94109 415.775.9956 ph 415.346.8652 fx

www.thesecondopinion.org

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Medical Intake Form--Form II

Name: _____ **Date of Birth:** _____ **Gender:** _____

Email: _____ **Phone:** _____
Home Mobile

Address: _____

County: _____

Contact person, if other than patient: _____

Contact person's phone and or email : _____

Type of Cancer: _____

When were you diagnosed with cancer? _____

Have you received a prior Second Opinion? _____ **If so where and when?** _____

Are you planning to Obtain Additional Opinions? _____ **If so where and when?** _____

☐ **I will need the help of translator services.** Which Language? _____

How did you hear about us?

Why are you seeking a second opinion?

Please tell us briefly about your cancer diagnosis and treatment to date. This will help us determine the records that will be needed for your panel review:

FORM III

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PATIENT HEALTH INFORMATION RELEASE FORM

I HEREBY AUTHORIZE:

_____
NAME OF HOSPITAL, DOCTOR, LABORATORY OR DEPARTMENT

_____
ADDRESS

_____
CITY STATE ZIP CODE

TO RELEASE TO: Howard B. Kleckner, 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: SECOND OPINION CANCER CONSULTATIVE PANEL

Duration: I understand that this authorization is effective immediately and shall be valid for one year.
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 RELATED TO CANCER DIAGNOSIS, INCLUDING LAB REPORTS, CONSULTATIONS, OPERATIVE REPORTS AND PATIENT SUMMARIES.
- ☐ IMAGING STUDIES, X-RAYS AND REPORTS, CT scans, MRIs and REPORTS
- ☐ MAMMOGRAMS, ULTRASOUNDS and REPORTS
- ☐ PATHOLOGY SLIDES AND REPORTS
- ☐ NUCLEAR SCANS AND REPORTS

Patient signature: _____ Date: _____

FORM IV: PHYSICIANS and MED INFO

Date: _____

Name: _____ **Phone:** _____
Home Mobile

Email: _____ **Type of Cancer:** _____

Have you received a prior Second Opinion? ____ **If so where and when?** _____

Are you planning to Obtain Additional Opinions? ____**If so where and when?** _____

☐ **I will need the help of translator services.** Which Language? _____

To the best of your knowledge, please list all physicians and medical facilities involved in your care. Addresses and phone numbers are appreciated.

Oncologist: _____ **, MD**
Facility/Hospital: _____
Address: _____
_____
Phone/Fax: _____
Dates under care: _____

Surgeon: _____ **, MD**
Facility/Hospital: _____
Address: _____
_____
Phone/Fax: _____
Dates under care: _____

Radiation Oncologist: _____ **, MD**
Facility/Hospital: _____
Address: _____
_____
Phone/Fax: _____
Dates under care: _____

Other _____: _____ **, MD**
Facility/Hospital: _____
Address: _____
_____
Phone/Fax: _____
Dates under care: _____

Hospital/Facility:

Medical Records Department: _____
Address:
_____

Radiology Department: _____
Address:
_____

Pathology Department: _____

Address: _____
Other Department: _____
Address:
_____

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FORM V: STATISTICAL QUESTIONNAIRE

Name: (initials) _____ **Age:** _____ **Date:** _____ **Gender:** _____

Type of Cancer: _____

How did you hear about our service? _____

The information below is used only to provide statistics to potential funding organizations. No names will be used.

Ethnic identity: With which ethnic group/s do you identify? (e.g. African American, Asian, etc.)

Are you: *(Please check the appropriate box.)*

☐ Employed ☐ Retired ☐ Unemployed ☐ Disability ☐ Other

Are you: ***(****Please check one box below.)*

☐ Single ☐ Married ☐ Widowed ☐ Divorced

Your Annual Income: (*Please check one box below)*

☐ $50,000 or Less ☐ $51,000 -$79,000

☐ $80,000-100,000 ☐ $101,000 or Above

Is your medical care covered by *(Please check all boxes that apply)*:

☐ Medical insurance: (e.g. Aetna, Kaiser, Healthy SF, Health Net,
☐ etc.) Medical Insurance and Medicare
☐ Medicare Only
☐ Covered California/Affordable Care Act: Kaiser, Blue Shield, etc.
☐ Medi-Cal
☐ Uninsured
Other

While we do not bill your insurance for our free services, we would like to know if your insurance or health plan covers the cost of a 2nd Opinion outside of your plan's network?
(Please check the appropriate box below.)

☐ Yes ☐ Partial with Co-Pay ☐ No ☐ I don't know