

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.

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: _____