

**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:** 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.
- X-RAYS AND REPORTS, CT scans, MRIs and REPORTS
- PATHOLOGY SLIDES AND REPORTS
- NUCLEAR SCANS AND REPORTS

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

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