IEO
European Institute of Oncology

IEO SECOND OPINION
AUTHORIZATION FOR THE COMMUNICATION AND THE MEDICAL REPORTS DELIVERY

All items on this authorization must be completed or the request will not be honored. Use "N/A" if not applicable.

Patient Name

_____
[first] [m. initial] [last]

Address:

_____
[street address]

_____
[city] [zip code] [country]

Birth Date: _____

I, the Patient, authorize the European Institute of Oncology to communicate all the clinical information to:

Name _____Surname_____

I, the Patient, authorize the European Institute of Oncology to provide the IEO Second Opinion to:

☐ me ☐ another person or entity

The Second Opinion should be sent to:

☐ e-Mail _____@_____
[insert email address]

☐ Fax _____
[insert fax number]

If you would like to receive the Second Opinion report via postal mail, please fill the following details. If you choose this option, the additional amount of 18,00€ will be charged.

_____
[insert name]

_____
[insert street address]

_____
[insert city, zip code and country]

I, the Patient, accept that:

- If I do not sign this authorization, IEO will not disclose the Second Opinion as requested
- I will receive a copy of this authorization upon signature.
- This authorization is valid for one year from date signed, unless I revoke this authorization or unless an earlier date is specified here: _____. I may revoke this authorization by mail to the following mail address second.opinion@ieo.it along with a copy of the original authorization duly signed.
- The medical information released may contain information related to HIV infection, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, genetic data and other important clinical information.

Date:_____

Signature of Patient or Legal Representative_____