

Date: [Date]

From:

[Patient Full Name]

[Date of Birth]

[Address]

[Phone Number]

To:

[Releasing Physician/Hospital Name]

[Department of Medical Records]

[Address]

RE: Authorization to Release Medical Records for Second Opinion

To Whom It May Concern,

I am writing to formally request a complete copy of my medical records to be transferred to the physician listed below for the purpose of an oncology second opinion consultation.

Receiving Physician Information:

Name: [Consulting Oncologist Name]

Facility: [Name of Institution/Clinic]

Address: [Full Address]

Phone: [Phone Number]

Fax: [Fax Number]

Please include the following records:

- Oncology consultation and progress notes
- Pathology reports and original slides (if applicable)
- Radiology reports and actual imaging files (CT, PET, MRI, etc.) on CD or digital portal
- Laboratory and blood work results
- Chemotherapy or radiation treatment summaries
- Surgical reports

I request that these records be sent via [Secure Email / Fax / Mail] by [Date].

Attached is my signed HIPAA authorization form. If there are any fees associated with this request, please notify me immediately.

Thank you for your prompt assistance in this matter.

Sincerely,

[Signature]

[Printed Name]