Dr. Vanni VERONESI
Website: www.vanniveronesi.com
YouTube Channel: https://www.youtube.com/@veronesisectionfilumterminale

SECOND OPINION
MODULE 3: Authorization for the communication and transmission of medical reports

# AUTHORIZATION FOR THE COMMUNICATION AND TRANSMISSION OF D R. VERONESI'S SECOND OPINION REPORTS

Please note that all fields must be filled out correctly for your request to be processed.
Please enter ND if the requested information is not available.

Patient Information: _____
[Name and Surname]

Address: _____
[Street/Avenue/Square]

_____
[Zip Code] [City] [Province] [Country]

Date of Birth: _____

The patient authorises Veronesi to communicate clinical information relating to the Second Opinion to:

Name_____ Surname _____

The patient authorises Veronesi to release the Second Opinion report to:

□ to himself □ to others

The requested Second Opinion report will be sent via (select your preferred method):

□ Email to the following address:
_____@_____

□ Fax to the following number:_____

The patient, the owner of the medical records, declares that he or she is aware that:
• Without the date and signature, this authorisation form is invalid.
• This authorization form is valid for one year from the date of signature, unless revoked or allowed to expire by the date indicated below: _____.
• The patient may revoke the authorisation in writing by email to: veronesi.secondopinion@gmail.com, attaching the originally signed authorisation form.
• The report may contain clinically relevant information.

Date _____

Patient or Legal Representative Signature _____