Patient Release Form

WorldCare Medical Second Opinion service

Patient information

Patient last name: _____ Patient first name: _____ Middle initial: _____

Patient date of birth (month/day/year): _____ Patient gender: ☐ Male ☐ Female

Street address: _____ City: _____ State/Province: _____

Postal code: _____ Country: _____ Phone number: _____

E-mail address(es): _____ Membership Provider/Policy #: _____

Your WorldCare Booklet will be delivered to you via secure email to the email address(es) above.
Please ONLY check the box below if you would like to receive a printed booklet via courier.

☐ *Send booklet via courier to the address above.*

Designated physician information

Please name a current care provider that will be your partner for the medical second opinion process and who will receive a copy of your completed WorldCare Booklet.

Last name: _____ First name: _____ Middle initial: _____

Street address: _____ City: _____ State/Province: _____

Postal code _____ Country: _____ Phone number: _____ Fax number: _____

Patient consent

I authorize:

- All of my medical providers, including, but not limited to, physicians and/or healthcare facilities, to disclose my medical files, including all records, imaging studies and pathology slides and/or blocks, to WorldCare.
- WorldCare to release my medical files including, but not limited to, all records, imaging studies and pathology slides and/or blocks to the hospitals of the WorldCare provider network to facilitate the specialist consult.

I understand the following:

- The participating hospital(s) will select one or more physicians ('consulting physician(s)') who will receive my Personal Health Information to render a consultation report.
- This consultation report will answer specific questions posed by my designated physician (above) and myself and will be sent directly to my designated physician to review it, discuss and, if possible, determine my treatment plan.
- My designated physician remains responsible for my primary diagnosis and treatment and if I have questions about the consultation report and how it affects my health or treatment I should raise them directly with my designated physician.

I have been informed of the following:

- I have the option to withdraw consent to have my Personal Health Information shared and used for this specialist consult at any time. I understand that requests to withdraw consent should be provided in writing.
- The consulting physician(s) and WorldCare are compliant with the Health Insurance Portability and Accountability Act (HIPAA) and treat all personal information and medical information as confidential.
- The consulting physician(s) and WorldCare will not share my Personal Health Information with any other person or entity, other than as described in this form, without my prior written consent.
- The risks and benefits of consenting, or refusing to consent, to the disclosure of my health information.

Signature: _____ Date: _____

(Electronic signatures are not accepted.)

Parent, guardian or other legally-authorized party *(For minors, incapacitated or mentally incompetent patients unable to give informed consent)*

Print Name: _____

Signature: _____ Date: _____

An authorized signature is required in order to begin the specialist consult process.

Fax completed form to 877.266.1150 or email to membercare@worldcare.com.

worldcare

7 Bulfinch Place, Suite 301, PO Box 8310
Boston, MA 02114

P 877.676.6439
F 877.266.1150
www.worldcare.com

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Authorized Contacts

If you do not wish to authorize any contacts outside of your healthcare providers, you DO NOT need to sign or return this page.

In addition to my healthcare providers, I also authorize WorldCare to communicate with and release my health information (including all copies of specialist's reports) to the authorized contact(s) below:

Name: _____ Phone: _____ Email: _____

Name: _____ Phone: _____ Email: _____

Please note, WorldCare can ONLY communicate with your authorized contacts using the phone/email information provided above.

Signature: _____ Date: _____

(Electronic signatures are not accepted.)

Parent, guardian or other legally-authorized party *(For minors, incapacitated or mentally incompetent patients unable to give informed consent)*

Print Name: _____

Signature: _____ Date: _____

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