



Second Opinion Consent

I have requested that Children's Healthcare of Atlanta ("Children's") provide a second opinion for me regarding the condition described below. Via this consult, Children's will provide me with the conclusions of the reviewing physician. The physician will reach those conclusions based solely on the information provided by me or my physician to Children's. Neither Children's nor any of its physicians, employees or affiliates shall have any liability or responsibility for the accuracy and completeness of that information or for any errors in its transmission.

By providing the physician's conclusions, Children's does not assume any continuing responsibility for my medical care or treatment. In addition, I recognize that, without a complete in-person physical examination, the physician will be limited in his or her ability to correctly assess or diagnose my condition and recommend treatment.

Although Children's has no obligation to obtain additional medical records or other information regarding my condition, I authorize my physician and any other person or entity to release any information pertaining to my health, including, without limitation, health history, present complaints and laboratory and diagnostic data to Children's. Children's is authorized, at its election, to obtain any such records and information.

For myself and my heirs, personal representatives, administrators, successors and assigns, I irrevocably release Children's and its insurers, officers, directors, physicians, employees and affiliates from any and all known or unknown, foreseen and unforeseen, claims, actions, losses or damages arising in connection with the consult or the physician's conclusions.

Patient's Current Diagnosis: _____

Patient Name (please print): _____

Patient/Parent Signature: _____ Date: _____

Witness Signature: _____ Date: _____