



**Friends Like Me  
Care Package Request Form  
For Healthcare Professionals**

**AUTHORIZATION FOR DISCLOSURE OF PROTECTED  
HEALTH INFORMATION**

I, \_\_\_\_\_ (patient's name or name of legal guardian or agent as signed below) authorize \_\_\_\_\_ (name of covered entity/ health provider) to disclose my name, contact information and date of diagnosis of breast cancer to The Pennsylvania Breast Cancer Coalition for the purpose of me receiving relevant information from them regarding my condition.

**PLEASE PRINT CLEARLY**

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_  
(No PO Boxes please – packages shipped via UPS)

City, State, Zip: \_\_\_\_\_

Phone number (with area code): \_\_\_\_\_

E-mail address: \_\_\_\_\_

**Date of diagnosis:** \_\_\_\_\_  
(Required)

*Optional Information*

By answering the following questions, we will be better able to customize a care package to suit the patient's specific needs. (please circle one)

- Does the patient have a partner/caregiver? Y N
- Patient's date of birth or age \_\_\_\_\_
- Is the patient currently receiving or planning on receiving chemotherapy? Y N
- Is the patient currently receiving or planning on receiving radiation treatments? Y N
- Is this a recurrence? Y N
- Does the patient have children living at home? Y N  
 Gender: M F Age: \_\_\_\_\_  
 Gender: M F Age: \_\_\_\_\_  
 Gender: M F Age: \_\_\_\_\_

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon it.

I understand that \_\_\_\_\_ (name of covered entity/ health provider) may not, and will not, condition treatment on whether I sign this authorization.

Unless revoked in writing, this authorization will expire in one year from the date listed below.

\_\_\_\_\_  
(Patient's Signature)

\_\_\_\_\_  
(Date Signed)

**REQUIRED information to be completed by healthcare professional.**

**SUBMITTED BY:**

Name (Please print): \_\_\_\_\_ Telephone: \_\_\_\_\_

Facility Name: \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE FAX THIS FORM TO: PA BREAST CANCER COALITION - 717-769-2131**