PA BREAST CANCER COALITION

Finding a cure now...
so our daughters won't have to.©

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)

1. Does the patient have a partner/caregiver? Y N
2. Patient's date of birth or age _____
3. Is the patient currently receiving or planning on receiving chemotherapy? Y N
4. Is the patient currently receiving or planning on receiving radiation treatments? Y N
5. Is this a recurrence? Y N
6. Has the patient been diagnosed with stage IV Metastatic Breast Cancer? Y N
7. 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