



Patient Authorization

In order for Cancer Outreach Foundation to determine my qualification for assistance and for them to determine the sources available for such assistance, I agree to provide required information and to authorize Cancer Outreach Foundation to obtain all information needed to determine my eligibility for requested assistance.

Patient Signature: _____

Date: _____

Spouse Signature: _____

Date: _____

Patient Disclosure

I _____ am a patient/and or the guardian/parent of _____.
I understand that I am required to inform Cancer Outreach Foundation of the persons to whom they may disclose my medical information. These assigned persons will also be able to speak on my behalf in regards to other personal details _____ (initial here). These assigned persons may be changed at any time to my discretion. This disclosure is effective _____ and will continue for one year thereafter.

I HAVE READ THE PERMITTED DISCLOSURE FORM AND ASSIGN THE FOLLOWING:

TRUSTEE: (Family member, lawyer, other who can access my medical information):

Name of Trustee: _____

Phone: _____ Address: _____

Name of Trustee: _____

Phone: _____ Address: _____