The Putt Away Cancer Foundation
"Circle of Hope"
Award Application

Name: _____ **Birthdate:**_____

HOME ADDRESS: _____

State/Zip _____ **Ph#**_____

Are you: **Working: Y / N** **Receiving Public Assistance: Y / N** **Disabled: Y / N**

Cancer Type: _____ **Diagnose Date:** _____

Status: **Remission** **Active** **If currently battling Cancer, what stage:**_____

Doctor Information: (Oncologist signature required to certify the applicant's eligibility).

Dr. Name: _____

Office #: _____

Hospital Affiliation:_____

_____

This is a statement to certify that (Pt Name)_____ **was a patient under my care. He/she, was treated for cancer mm/yyyy)**_____**.**

Patient Signature:_____ **Date:**_____

Doctor Signature:_____**Date:**_____

Date Application RCVD: _____

Board Review Initials: _____

CONSENT FOR USE, DISCLOSURE AND/OR RELEASE

OF PERSONAL AND HEALTH INFORMATION

APPLICANT INFORMATION:

DATE	CANCER DIAGNOSIS	YEAR OF DIAGNOSIS	CURRENT STATUS

DEMOGRAPHIC INFORMATION

LAST NAME	FIRST NAME/MIDDLE INITIAL	DATE OF BIRTH
ADDRESS	CITY, STATE, ZIP CODE	PHONE NUMBER

I. PERSON OR AGENCY *REQUESTING* THE INFORMATION:

The Putt Away Cancer Foundation can request my personal health information (The information to be released is described in Section III below.)

Agency Name: The Putt Away Cancer Foundation

Address: 5427 Park Lake

City, State, Zip Code: San Antonio, TX 78244

Agency Contact and Title: Latheasa Stevens, Board Secretary

Telephone No.: 512-270-0128

II. PERSON OR AGENCY *PROVIDING* THE INFORMATION:

The persons or agency may release my personal, health, and/or education information: (The information to be released is described in Section III below.)

Agency Name:

Address:

City, State, Zip Code:

Agency Contact and Title:

Telephone No.:

III. INFORMATION THAT MAY BE RELEASED:

The persons or agencies marked in Section IV below may view, copy, release and exchange the information or records marked below *(all that apply have an X)*. This information may be shared verbally, in writing, and/or by email or fax:

☒ Medical Information, including but not limited to operative, emergency,

☒ Family Information, including but not limited

radiology, consultations, progress notes.	to size of family, family income, family support.
☐ Developmental Information	☐ Educational Records
☐ Speech/Language Information	☐ Developmental Screening Information
☐ Other:	☐ Other:

SPECIFIC AUTHORIZATIONS:

The following information will not be released unless you specifically authorize it by marking the relevant box(es) below:

☐ I specifically authorize the release of information pertaining to my claim of having been diagnosed with cancer.

☐ I hereby authorize The Putt Away Cancer Foundation to utilize my name___and/or photograph____ for media release.

MY INFORMATION MAY BE USED TO:

1. Screen for a The Putt Away Cancer Foundation "Circle of Hope" Award.
2. Validate that I have been diagnosed with cancer, whether in the past or presently.
3. For publication as a recipient of the Award.

IV. INFORMATION MAY BE EXCHANGED BY THE FOLLOWING PERSONS OR AGENCY(IES):

I know that the service team includes the persons and/or agencies marked below *(All that apply have an X)*:

☒ Healthcare Services

☒ Primary Health Care ☒ Oncologist

☒ Other Agency: The Putt Away Cancer Foundation

Please initial and sign where prompted:

VOLUNTARY: I know that I do not have to sign this consent form. I can refuse to sign this consent form, or alter the privileges of what I am willing to disclose. However, I understand that if The Putt Away Cancer Foundation is unable to validate that I have had a cancer diagnosis, I will be disqualified from obtaining the Award._____(initials)

LENGTH OF TIME: This consent will be valid from the date that I sign this form until _____(date). If no date is entered, the form will be valid for one year after the date that I sign the form.

WITHDRAWAL: I know that I can withdraw this consent at any time. To withdraw my consent, I must send a written note to the person or agency in Section I. The withdrawal will be valid as soon as the person or agency gets my note, but will not apply to information that has already been shared after I signed the consent form.

_____(initials)

SHARING OF INFORMATION: I know that my information may be shared more than once by the persons and/or agency(ies) in Sections I and II. The information may no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). It may still be protected by other State and Federal laws. _____(initials)

COPY: A copy of this consent form will be as good as the original. I know that I have a right to get a copy of this consent form if I ask for one. _____(initials)

Signature:	Date: