

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

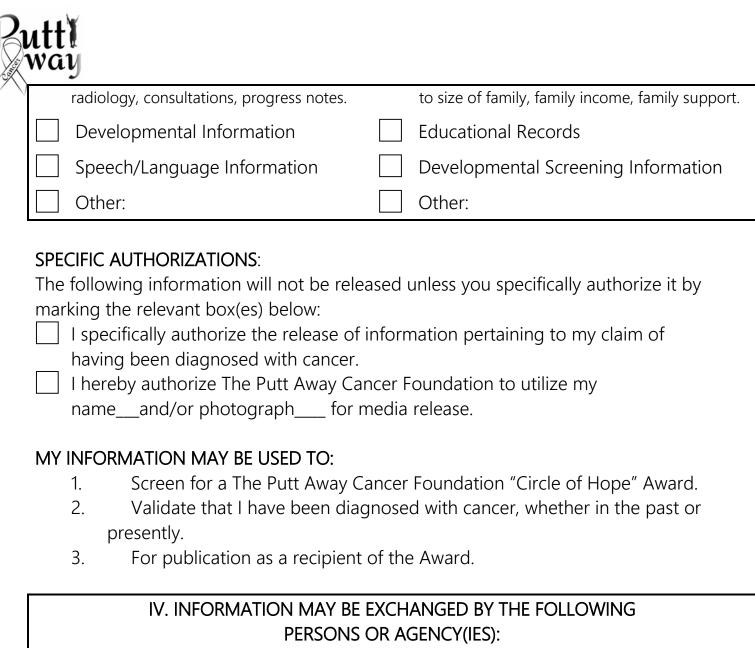
Name:	Birthdate:			
HOME ADDRESS:				
State/Zip	Ph#			
Are you:	Working: Y / N Receiving Public Assistance: Y / N Disabled: Y / N			
Cancer Type:	Diagnose Date:			
Status:	Remission Active If currently battling Cancer, what stage:			
Doctor Information: (	Oncologist signature required to certify the applicant's eligibility).			
Dr. Name:				
Office #:				
Hospital Affil	iation:			
	o certify that (Pt Name) was a patient under meated for cancer mm/yyyy)			
Patient Signature:	Date:			
Doctor Signature:	Date:			
Date Application RCVD	:			
Board Review Initials:				



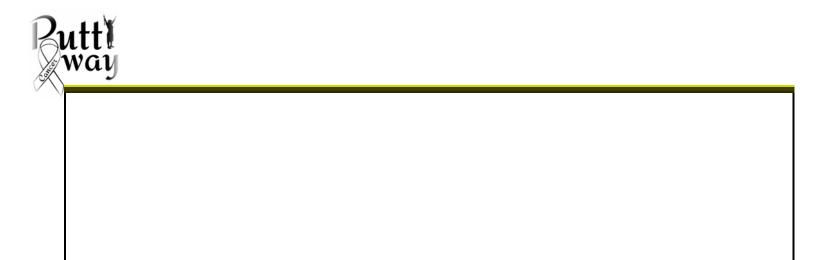
## CONSENT FOR USE, DISCLOSURE AND/OR RELEASE

## OF PERSONAL AND HEALTH INFORMATION

Applicant information	ON:						
DATE	Cancer Diagnosis		Year of Diagnosis	Current Status			
DEMOGRAPHIC INFORMA	ATION						
LAST NAME		FIRST NAME/MIDDLE INITIAL		Date of Birth			
Address	Address		ODE	Phone Number			
I. PE	I. PERSON OR AGENCY <i>REQUESTING</i> 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		easa Stevens	, Board Secretary				
Telephone No.: 512-							
II. PERSON OR AGENCY <u>PROVIDING</u> 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	<u>(.)</u>			
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 verb	pally, in writin	ng, and/or by email	or fax:			
Medical Information, including but not Family Information, including but not limited							
limited to operativ	limited to operative, emergency,						



## 



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)

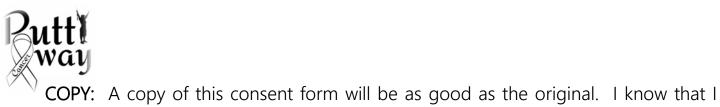
LENGTH OF TIME: This consent will be valid from the date that I sign this form until \_\_\_\_\_\_(date). If no date is entered, the form will be valid for one year after the date that I sign the form.

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)



have a right to get a copy of this consent form if I ask for one(initials)					
Signature:	Date:				