the samfund

support for young adult cancer survivors

AUTHORIZATION TO RELEASE MEDICAL RECORDS (2018)
Please print this form out, fill it out, scan it, and upload it to your application file as a PDF.

*If you cannot upload this form yourself, please fax it to 1-866-496-8070 by **August 15th, 2018** in order to guarantee it will be received and uploaded by the deadline.

DO NOT SEND THIS FORM TO A PHYSICIAN—PLEASE COMPLETE AND SIGN YOURSELF.
Only one form is required per applicant, even if you were treated by multiple physicians.

Name of Patient _____

Address _____

Date of Birth _____ **Telephone Number** _____

1. I hereby authorize and consent to the release of my medical record (as circumscribed in Section 2, below) by _____ (**name of doctor/hospital**) for a time period beginning as of the date I sign this Authorization and ending on ____/__/2019_____(**one year from today's date**). The record should be released and sent to: The Samfund, 89 South Street, Suite LL02, Boston, MA 02111, Attn: Samantha Watson. The purpose of this release is to allow The Samfund to consider my application and eligibility for certain grants and scholarships.

2. I authorize the release of my medical record only as it relates to the diagnosis and treatment of cancer, including, but not limited to, all consultation and therapy notes, correspondence, evaluations, examination data, prescriptions and bills for medication, and all other documents for diagnosis and treatment of cancer (for the period from _____ to _____(**dates**)).

3. A photocopy of this authorization shall be considered as effective and valid as the original.

4. I have carefully read and understand the above statements, and do expressly and voluntarily consent to disclosure of my medical records as described in this Authorization. I understand that I may revoke this Authorization at any time in writing, provided that my revocation shall not apply to any release of my medical records and information that predates my revocation notice.

Signature of patient: _____

Date: _____