Cancer Angels of San Diego

Authorization for Release of Medical Records and Information

_____

Agency/Individual **From Whom** Information is Requested (e.g., your physician)

Address: _____

_____

_____

_____

I, _____, residing at _____,
(please print) (home address)

hereby authorize you to release to Cancer Angels of San Diego, non-profit organization #26-1099989 specific information requested by them which I cannot provide concerning diagnosis, prognosis, treatment:

- _____
- _____
- _____
- _____
- _____

This information is needed to determine my eligibility for assistance from Cancer Angels of San Diego.
I have read this form and have agreed to its request prior to my signing.

_____	_____
Print name	Social Security Number
_____	_____
Date of birth	Birthplace
_____	_____
Signature of Applicant	Date

Note: Provide this form to the physician or other agency from whom you are requesting the release of information to Cancer Angels of San Diego.

CANCER ANGELS OF SAN DIEGO
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