A local charity serving Greater Tulsa

Diagnosis Confirmation Form

Applicant's Name: _____

Complete Mailing Address: _____

Date of Birth: _____

I hereby authorize _____ (Name of Current Treating Physician) to release or disclose to B.C.A.P. my medical information pertaining to my current diagnosis and prognosis, surgeries and treatments. I further authorize you to discuss with B.C.A.P. any confidential information with respect to my medical condition or treatment and any confidential information with respect to my financial situation. I understand the purpose of this disclosure is for use in pending application for financial assistance by B.C.A.P. I understand that my name, personal, financial and medical information will be kept confidential unless I give specific permission otherwise. This authorization will expire one year after the date of signature below.

Applicant's Signature: _____ Date _____/_____/_____

Patient fills out top portion of form and gives to current treating physician

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Physician fills out bottom portion of form and fax form to BCAP at 918-932-2908

Type of Cancer: _____

Date of Initial Breast Cancer Diagnosis _____/_____/_____/ Date of Surgery _____/_____/_____

Chemo Start Date _____/_____/_____ Chemo End Date ____/_____/_____/

Radiation Start Date _____/_____/_____ Radiation End Date _____/_____/_____

Treating Physician Name: _____

Complete Address: _____

Phone Number: _____

Physician Signature: _____Date _____/_____/_____