Sparta Area Cancer Support Inc.

Return to:
SACS Inc.
P.O. Box 130
Sparta, WI 54656

Date:_____

Name_____Phone number_____

Address_____ Years at address_____

Diagnosis_____

Physician_____ Clinic/Hospital Name_____

Request for Assistance: check box below & add comments as needed

Fuel_____Gas Cards_____Groceries_____Medical_____

Costs_____Medication_____Other_____Transportation_____

Comments:_____

_____

_____

Emergency Contact Name_____ Phone number_____

Board Action on Request_____

_____

_____

Recipient Signature

_____

Board Member Signature

_____

Authorization for Release of Health Information

Patient Name:_____ **Previous/Maiden Name:**_____

Address:_____

Phone number:_____ **Date of Birth:**_____

Authorizes Release of Information from:

_____
Name of Medical Clinic

_____
Street Address

_____
City, State, Zip Code

Release of Information to:
Sparta Area Cancer Support, Inc.
P.O. Box 130
Sparta, WI 54656

Information is to be related for the following dates:_____

Purpose for Need of Disclosure: Confirmation of cancer diagnosis and active cancer treatment to meet eligibility requirements to receive financial support from the Sparta Area Cancer Support, Inc.

I understand by signing this authorization that eligibility may not be conditioned by signing this authorization. This authorization may be revoked, in writing, at any time prior to the disclosure of this information. This information may be protected by numerous Federal laws relating to confidentiality prohibiting any further disclosure. This information is intended for the recipient only and any further disclosure by recipient is no longer protected by HIPPA Privacy rule. I also understand I have the right to inspect and receive (upon reasonable notice and for a reasonable fee) a copy of the material to be disclosed as well as a copy of this authorization form. If not previously revoked, this authorization will expire in 6 months from the date of my signature. A photocopy of this authorization is considered as valid as the original.

Patient signature_____ Date_____ Time_____

Signature of Legal Representative_____ Date_____ Time_____

Relationship_____

Witness_____ Date_____ Time_____