





Please fill in ALL fields of this form. Only complete applications will be processed. Please print out completed application and mail to address below for processing.

**Patient Information**

Last Name	First	Middle	
Street Address	City	State	ZIP Code
Phone ( )	Fax ( )	Email	

**Physician Information**

Last Name	First	Middle	
Title	State License Number	Clinic or Hospital Name	
Street Address	City	State	ZIP Code
Phone ( )	Fax ( )	Email	

**Treatment Information**

Cancer Type

**Treatment plan (Please check all that apply)**

- Surgery to the reproductive area, please explain:
- Radiation to the brain or reproductive area, please explain:
- Chemotherapy, please explain:
- Other, please explain:

Treatment time line: Start Date	End Date
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Please check yes or no; incomplete answers will delay processing

My intended treatment plan presents a risk that the patient may become infertile.

- Yes  No

Oncologist Signature



Date



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**Patient Information**

Last Name	First	Middle	
Street Address	City	State	ZIP Code
Phone ( )	Fax ( )	Email	
Cancer Type:			

**Physician Information**

Last Name	First Name	Middle	
State License Number	Certification Affiliation		
Street Address	City	State	ZIP Code
Phone ( )	Fax ( )	Email	

**Treatment Plan**

- Embryo Freezing
- Egg Freezing
  - Step One
  - Step Two
- Sperm Banking

Reproductive Endocrinologist Signature



Date



# Caporal Assistance Network

Providing Hope To Young Adults Living With Cancer

## AUTHORIZATION FOR RELEASE OF INFORMATION

### I. Information About the Use or Disclosure

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information.

Participant name: \_\_\_\_\_ ID Number: \_\_\_\_\_

Name of the Covered Entity authorized to provide the information: \_\_\_\_\_

Persons/organizations authorized to receive the information: \_\_\_\_\_

Description of information to be used or disclosed (including date(s)): \_\_\_\_\_

Specific purpose of the disclosure (Note: If this authorization is being made at your request, you may state "This is done at my request" and leave the rest blank unless you choose to state a purpose.): \_\_\_\_\_

If a health plan or provider is requesting to receive the information described on this form, will that plan or provider receive financial or in-kind compensation in exchange for using or disclosing the health information described?

No \_\_\_\_\_ Yes (describe) \_\_\_\_\_

This authorization will expire one year from the date next to my or my personal representative's signature below, or earlier upon the occurrence of the following event \_\_\_\_\_ (must relate to the purpose of the authorization).

### II. Important Information About Your Rights

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing, **but I understand that the revocation will not effect any actions the entity took before I revoke my authorization.**
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive health care benefits to which I am otherwise entitled.
- The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving entity and I understand that the information may no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (also known as HIPAA).

### III. Signature of Participant or Participant's Representative

\_\_\_\_\_  
SIGN HERE

Signature of participant or representative

Date

(Form MUST be completed before signing.)

Printed name of the participant: \_\_\_\_\_

Printed name of the participant's personal representative: \_\_\_\_\_

Relationship to the participant, including authority for status as representative: \_\_\_\_\_

**\*\* YOU MAY REFUSE TO SIGN THIS AUTHORIZATION \*\***

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