PO Box 1382 Rolla MO 65402 Cancer Gala & Co cancergalaandco@gmail.com

This page must be completed and signed by a referring health care professional (Physician, Nurse, Patient Navigator, Case Worker or Social Worker)
Please do not use abbreviations or codes for diagnosis and treatment. Do not send medical records. Please answer each question completely.

MEDICAL VERIFICATION and PATIENT INFORMATION FORM	
Patient's Full Name:	
Cancer Diagnosis:	Diagnosis Dates:
Name of Diagnosing Physician:	
AUTHORIZATION OF PATIENT	
I hereby authorize the below person to provide this completed form, with my personal protected health information, to the Cancer Gala Board, with my application for Financial Assistance: Date: Signature of Patient:	
REFERRING PROVIDER or CASEWORKER INFORMATION:	
Name of Referring Professional (completing this form) and treating Facility Name:	
Address, City, State and Zip Code:	
Phone:	Email:
Date you last saw this patient:	
My Signature below affirms the diagnosis and treatment information as described on this page:	
Signature of referring party:	Date: