Verification of Cancer Diagnosis

TO BE COMPLETED BY PATIENT:

I, (please print) _____ authorize this practitioner to provide the information on this form due to my request, and to verify the information as required is accurate.

_____ _____

PATIENT SIGNATURE **DATE**

TO BE COMPLETED BY THE LICENSED PRACTITIONER:

Date of Diagnosis: _____

Diagnosis: _____

Treatment: _____

Treating Facility: _____

Treating Physician: _____

_____ _____

LICENSED PRACTITIONER **DATE**

==========