The Gail Robinson Fund

Referral/Recommendation Form and HIPPAA Release

Directions: This form may be submitted in support of an application for a Grant from the Gail Robinson Fund. It may be submitted by a hospital or physician social worker, nurse navigator, physician office practice manager or other individual who is familiar with the patient's application for a grant and the circumstances described in the application.

To be filled out by the ***Patient:***

Name:_____

Date of Birth _____/_____/_____ (month/day/year)

Address: _____

_____

_____

State _____ ZIP_____

I authorize _____ (the individual listed on this referral/recommendation form) to release and disclose the information relating to the diagnosis and treatment of my metastatic breast cancer to the Gail Robinson Fund in connection with my application to the Fund for financial assistance. This authorization is from the date this authorization is signed until such time as the Fund has made a decision regarding my application, not to exceed 90 days unless I extend this authorization in writing. I understand I may revoke this authorization at any time.

Patient Signature _____

Date: _____

(continued on next page)

The Gail Robinson Fund

To be filled out by the ***Person making the referral or recommendation:***

Name:_____

Title/Role_____

Professional Affiliation (Physician Office, Hospital, or other office or facility) and Address:

_____

_____

_____

State _____ ZIP_____

Phone Contact: _____

Email: _____

I support the Patient's application for a grant from the Fund and agree to be contacted by a representative of the Fund in connection with the patient's application for a grant.

Signed: _____

Date: _____

To the Patient: Please return this form *along with a completed Grant Application to*:

The Gail Robinson Fund

c/o Steve Larsen, Fund Administrator

P.O. Box 508

Kensington, Maryland 20895