



# Medical Authorization Form

**Must Be Completed By The Nominee's Treating Physician**

1. Patient's Name: \_\_\_\_\_
2. Patient's DOB: \_\_\_\_\_ Date Of Patient's Last Visit: \_\_\_\_\_
3. Patient's Diagnosis: \_\_\_\_\_
4. Is This Diagnosis Considered Life Threatening?  YES  NO
5. Patient's Prognosis: \_\_\_\_\_
6. Any Other Pertinent Information? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*I hereby certify that I am the treating Physician of this patient. I have completed the requested information or have authorized a qualified staff member to do so on my behalf.*

\_\_\_\_\_  
Physician's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's or Staff Representative Signature

\_\_\_\_\_  
Physicians' Office Phone No.

\_\_\_\_\_  
Physician's Name Of Practice or Affiliated Hospital (If Applicable)

\_\_\_\_\_  
Physician's Office Address

You Can Scan & Email This Form To: [wishes@grantedwish.org](mailto:wishes@grantedwish.org)  
Or You May Send It Through Postal Mail To The Address Above