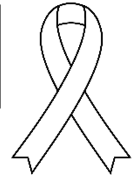
NOTE: Complete this form and give to your doctor. Doctor must mail medical information to Cancer Thrift Store of Beaufort. We cannot accept emails or faxes.



The Cancer Thrift Store of Beaufort

129 Burton Hill Rd. Ste. E Beaufort, SC 29906 • (843) 524-3100 • cancerthriftstore@gmail.com

Authorization to Release Medical Information

Re: Patient Name: ___________________________________

Patient Date of Birth: ________________________________

Patient SSN: ___________________________________

Today's Date: ______________________

Patient's Signature of consent:

I, ______________________________, hereby authorize the release of medical information to
(*patient signature here*) The Cancer Thrift Store of Beaufort.

To patient's doctor office:

The Cancer Thrift Store of Beaufort is a non-profit organization that provides financial assistance to local cancer patients. It is our understanding that the above-mentioned applicant is a patient at your facility**.** For us to further assist your patient's financial needs, we ask that you **please provide us with medical information regarding the patient's cancer diagnosis and treatment status.**

This organization provides assistance on a month to month basis; therefore, we may inquire about medical information regarding this patient each month that they apply to our foundation. This authorization to release medical information expires one year from the date listed above. If you have any questions or comments, please feel free to contact us using the contact information above. *Please mail medical information to The Cancer Thrift Store of Beaufort; 129 Burton Hill Rd; Beaufort, SC 29906*

Thank you,
The Cancer Thrift Store of Beaufort

Cancer Thrift Store Office Use Only

Date Received: ________ **By:** _________ **Notes:** ____________________________________