CareBOX PROGRAM

Patient Consent & Verification Form

It is important that the patient or parent/guardian reads the Patient Consent section below, completes the information required, and signs the form. A representative at the patient's treating facility will need to complete the Oncology Treatment Verification section.

Patient Consent

Patient Name: _____ Date of Birth: _____
First Last MM/DD/YYYY

Parent/Guardian
(If applicable): _____ Relationship to Patient: _____

Patient Email: _____ Patient Phone Number: _____

I understand that CareBOX Program may publish my first name, gender, diagnosis, and any "about me" information I share on the Wish List Builder on CareBOXProgram.org, social media forums, email, and other print and electronic outreach sources. I agree to allow photos of myself, donated items & testimonials I share during the CareBOX Program process to be taken and used by CareBOX Program. CareBOX Program can exchange medical information with my Referring Facility that will be used for the purposes of this program only. I understand that nothing contained herein constitutes medical advice, prescription, or treatment. I will seek a physician's advice before utilizing the contents delivered to me. It is my intention by this liability waiver and release to exempt the CareBOX Program and all Officers, Directors, Affiliates and Agents from any/all liability whatsoever for personal injury, property damage and wrongful death due to the use of items provided.

Signature: _____ Date: _____

Oncology Treatment Verification

Please have a representative from your treating facility fill out this section

Oncologist Name: _____ Treating Facility: _____

Healthcare Representative: _____ Title: _____

Email: _____ Phone: _____ - _____ - _____

Signature: _____ Date: _____

*By signing on behalf of this facility, I confirm that the information above is accurate.

Return this completed form via email to info@careboxprogram.org or fax to 512-296-2021
Questions? Visit careboxprogram.org or call 512-296-2180