Patient Consent & Verification Form

This form verifies that the patient has been diagnosed with cancer. 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 Cancer Diagnosis 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 grant the CareBOX Program the right to publish my first name, gender, diagnosis, and any "about me" information I share on the Wish List Builder on CareBOXProgram.org, and other print and electronic outreach sources. In addition, the CareBOX Program can communicate with my Referring Facility for the purposes of this program only. I understand that nothing contained herein constitutes medical advice, prescription, or treatment and agree to seek a physician's advice before utilizing the contents delivered to me. By signing this liability waiver and release, I agree 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:_____

Cancer Diagnosis 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