

CareBOX Program

Patient Consent and Diagnosis Verification Form

Welcome to the CareBOX Program!

We are so glad you completed the CareBOX Program Wish List Builder. Your specific Wish List will be completed and posted at CareBOXProgram.org within 24 hours of us receiving this signed form back from you. It is important that you read the Patient Consent section below, complete the information required and sign the form. You will also need a representative at your treating Oncology facility to complete the Oncology Treatment Verification section completely and sign as well. Please scan and email the completed form to info@careboxprogram.org.

We look forward to getting you the care supplies you need to feel CaredFOR.

Patient Consent	
Patient Name:	Date of Birth:
First Last	Date of Birth: MM/DD/YYYY
Parent/Guardian (If applicable):	Relationship to Patient:
Patient Email:	Patient Phone Number:
I understand that CareBOX will publish my first name, gender, diagnosis, and any "about me" information I shared on the <i>Wish List Builder</i> on CareBOXProgram.org, social media forums, email, and other print and electronic outreach resources. I agree to allow photos of myself, donated items & testimonials I share during the CareBOX 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. Nothing contained herein constitutes medical advice, prescription, or treatment. I will seek a physicians advice before utilizing the contents of the CareBOX. 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 the CareBOX items.	
Signature:	Date:
Oncology Treatment Verification *Please have a representative from your Oncology care provider fill out this section*	
Oncologist Name:	Treating Facility:
Healthcare Representative from Treatment Facility:	_ Title:
Email:	Phone:
Signature:	Date:
*By signing on behalf of this facility, I confirm that the information above is accurate.	