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LETTER OF DIAGNOSIS

Ovarian and other gynecological Cancers

Client Name:	Date of Birth

CLIENT CONSENT TO RELEASE INFORMATION

I authorize my medical provider to release information about my medical condition for purposes of verifying my eligibility to the agency listed above.

Signature:_____Date:_____

All certificates are subject to verification.
Fraudulent documentation may lead to termination of services.

PROVIDER VERIFICATION

Type of cancer: _____ Diagnosis date : _____

Clinical Stage: Unknown ___ DCIS ___ I ___ II ___ III ___ IV ___ Other _____

Date of most recent surgery: Month:_____ Year: _____

Current Treatment: Radiation ____ Chemotherapy ____ Hormonal Therapy _____

Other _____

Date current treatment began on: _____

Oncologist: _____

Medical Facility: _____

My signature certifies that the above named client has a gynecological cancer and is in active treatment.

_____ _____ _____

Signature of Physician, Nurse, LCSW or MSW Phone & Fax Date

Printed Name of Provider _____

Office Address _____