

P.O. Box 1379 Easton, PA 18044
Lauren Pennock (732) 673-6719
Krista Kasper (732) 904-7885
myhappyplace@mamamare.org
Fax (610) 252-6657



My Happy Place
Patient Application Form (Page 2)
(Patient must be a New Jersey Resident)

Applicant's First Name

M.I.

Last Name

By signing below, I (the patient/application named above) hereby authorize my physician and/or healthcare providers to release information to The Mama Mare Breast Cancer Foundation and its representative agents to the extent necessary for the purpose of confirming that I have been diagnosed with breast cancer and that I have undergone chemotherapy and/or other cancer treatments. I further authorize The Mama Mare Breast Cancer Foundation to contact my physician and/or healthcare provider to reconfirm this diagnosis. All patient information obtained by The Mama Mare Breast Cancer Foundation either from healthcare providers, the patient, or the patient's family, will be kept strictly confidential and used solely for the purpose of ascertaining need and providing appropriate assistance and services to the extent possible.

Patient's Signature

____/____/____
Today's Date (mm/dd/yyyy)

Physician's Section

____/____/____
Date of Diagnosis

Type of Breast Cancer

Stage (0-IV)

Please indicate the type(s) of treatment this patient has received:

Surgery _____ Chemotherapy _____ Radiation _____

Referring Physician Name _____

Physician's Signature _____

Physician's Phone # and/or Email Address _____