The APG Foundation
Confirmation of Diagnosis Form

Instructions:

1. *Form must be signed by patient in the presence of physician or authorized office personnel.*
2. *Form must be completed and signed by patient's attending physician or authorized office personnel.*
3. *Form must be accompanied by The APG Foundation application and be submitted to The APG Foundation.*

Patient authorization for release of information

I, _____, hereby authorize the release of the
(Please print name)
medical information (as specified below) to The APG Foundation as confirmation of my cancer or blood disease diagnosis. This information will be used exclusively to determine eligibility for assistance by The APG Foundation for my benefit.

Patient Signature: _____ **Date:** _____

Physician only below this line

Physician Confirmation of Diagnosis

Patient Diagnosis:

_____

_____

_____

Physician's Name (Please print): _____

Physician Signature: _____ **Date**: _____
(or authorized office personnel)

Telephone: _____

Please attach to the The APG Foundation Application for Assistance Form and mail
To: The APG Foundation, P.O. Box 1248, Cedar Rapids, IA 52406-1248
Or, Scan completed form and email to: apgfoundation@hotmail.com

Telephone: (319) 573-6136
www.apgfoundation.org

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