Patient Release of Information

I consent and agree to authorize KW Cares to obtain and discuss information related to my grant application with my physician and/or insurance company and/or pharmacy.

_____ _____

Print Name Date

_____

Signature

Physician's Statement

Dear Physician:

Your patient has applied to Keller Williams Realty Cares (KW Cares), a 501(c)(3) charity, for financial assistance. In order to process this application, we must verify the following information, and may contact you for additional information if needed. Please contact KW Cares with any questions you may have. Thank you.

This completed form should be mailed, emailed or faxed to:

KW Cares
1221 S. Mopac Expwy.
Suite 400
Austin, TX 78746
Phone: 512-439-8841
Fax: 435-514-2229
kwcares@kw.com

Patient's Section (Patient, please fill out this section)

Print Patient Name: _____ Last Four Digits of Patient's SSN: _____

Physician's Section

Print Name: _____ License Number: _____

Address: _____

Phone: _____ Fax:_____

Patient Diagnosis: _____

Diagnosis Date: _____

Patient Prognosis: _____

Other Pertinent Information: _____

Physician's Signature: _____ Date: _____