CSP-FLR Enrollment Proxy

I\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ give permission to **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(Print name) (Print name)

my **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,** to speak to the Cancer Services Program of Finger Lakes Region

(Relationship to me)

Staff on my behalf. The above mentioned individual is authorized to provide all information necessary for me to enroll in the program to include health history and financial status. I also give permission for the above mentioned individual to receive information about my medical findings and further follow up care. This permission expires in one year from the date of this proxy.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Signature*  *Date of Birth***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Phone number***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Date***