I, _____ give Pink Pink Out For Hope permission to obtain my protected health care information in coordination with possible benefits.

Please Print Clearly

Full Name:_____ Date of Birth:_____

Address:_____

City:_____ State:_____ Zip Code:_____

County:_____ Last 4 Digits of Social Security #:_____

Home Phone:_____ Cell Phone:_____

Email Address:_____

Signature:_____ Date:_____

Pink Out For Hope does not discriminate based on any information received.

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Pink Out For Hope is a 501 (C) (3) of the Internal Revenue Code.

Raising Awareness \ Funding Research \ Assisting Patients