Participant Contact Consent Form

Name: ______________________________

Address: ______________________________

City and Zip: ______________________________

Home Phone: ______________________________

Work Phone: ______________________________

Date of Birth: ______________________________

Date of Diagnosis: ______________________________

Breast Cancer Stage & Type: ______________________________

Other information: ______________________________

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I give consent for my medical care provider to share the above information with ABCD for the purpose of ABCD contacting me to discuss free, personalized information and one-to-one support.

Signed: ______________________________

(May be signed by patient or healthcare provider obtaining consent)

Referred by: ______________________________

Title & Institution: ______________________________

Phone number: ______________________________

Please fax completed form to:

(414) 918-9223 (until December 16, 2012)

(414) 977-1781 (effective December 19, 2012)

Or email: abcdinc@abcdmentor.org