Help Us Solve
The Cruel Mystery
LUPUS™
FOUNDATION OF AMERICA
TEXAS GULF COAST CHAPTER

Patient Access to Healthcare
MEDICAL RELEASE

TO BE COMPLETED BY PATIENT:

I, _______________________________ give permission to Dr.____________________________ to release medical information regarding my lupus diagnosis to the Lupus Foundation of America, Texas Gulf Coast Chapter Patient Access to Healthcare Program. I understand that this information will be used for the purpose of qualifying me for assistance.

_________________________________ _________________________________
Name (please print) Signature of Applicant

_________________________________ __________________________________
Date Date of Birth

____
Street Address

____
City State Zip

TO BE COMPLETED BY DOCTOR'S OFFICE:

VERIFICATION OF LUPUS

The above applicant has a diagnosis of lupus.
□ Yes □ No

He/She is taking the following medications (please include dosage):_________________________

____

He/She needs the assistance of the following medications (please list):_______________________

____

Additional
Information/Comments:____

____

__________________________________ _________________________________
Name of Physician or Authorized Representative (please print)
Signature of Physician or Authorized Representative

__________________________________ __________________________________
Date Office Phone

Thank you for taking the time to complete this form. If you have any questions, or would like further information on our program, please call the Lupus Foundation of America, Texas Gulf Coast Chapter at *(713) 529-0126. Please sign and fax or mail to:*

Lupus Foundation of America, Texas Gulf Coast Chapter
3701 Kirby Drive, Suite 700
Houston, TX 77098
Phone: 713-529-0126 or 800-458-7870 Fax: 713-529-0780