PEER SUPPORT APPLICATION

ONSITE REGISTRATION FORM

Please email completed both the Peer Support Application and the Authorization to Use and Disclose Protected Health Information (Imerman Angels) to peermentor@sentara.com.

SELECT OPTION:

Please complete "Survivor Contact Information" and "Treatment Status" sections below.

- ☐ Give Survivor Support
- ☐ Receive Survivor Support

Please complete "Caregiver Contact Information" and "Treatment Status" sections below.

- ☐ Give Caregiver Support/Become a Caregiver Mentor
- ☐ Receive Caregiver Support/Request a Caregiver Mentor

SURVIVOR CONTACT INFORMATION:

Name ______________________ Date ____________

Address ______________________

City/State ______________________

Phone ______________________ Email ______________________

Date of Birth ______________________ Gender ☐ M ☐ F

CAREGIVER CONTACT INFORMATION:

Name ______________________

Address ______________________

City/State ______________________

Phone ______________________ Email ______________________

Date of Birth ______________________ Gender ☐ M ☐ F

TREATMENT STATUS:

☐ Newly Diagnosed Date Diagnosed ______________________

☐ Currently in Treatment ☐ Finished with Active Treatment ☐ Living with Cancer

☐ Other (please specify) ______________________

Type of Cancer/Genetic Mutation ______________________

Stage of Cancer (circle one) 0 1 2 3 4 N/A / Unknown

SENTARA CANCER NETWORK *in partnership with* IMERMAN ANGELS *Your One-on-One Cancer Support Community*

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (IMERMAN ANGELS)

Please email to peermentor@sentara.com

Full Name ______________________ Date of Birth ______________________

Medical Record Number ______________________ Phone ______________________

#Address ____

Pursuant to this Authorization, I voluntarily give **Sentara Healthcare** permission to use and disclose the following personal health information:

☐ Only the information contained in the "Peer Support Application – Onsite Registration Form" for the Imerman Angels Peer Support program

I request **Sentara Healthcare** disclose and provide a copy of this information to the following individual/entity (name, address, phone and/or fax required):

Name **Imerman Angels** Address **205 W. Randolph, 19th Floor, Chicago IL 60606**

Purpose of this Authorization:

☐ At my request
☐ Other: ____

This Authorization will expire: ☐ Date: ☐ Event: ______________________

Unless otherwise specified, this Authorization will expire one (1) year after the date of this Authorization.

By signing below, I understand that:

- The personal health information listed above will be released to the individual/entity listed above in the manner specified above, and once disclosed, **Sentara Healthcare** will no longer have any control over the information;
- Information used and/or disclosed, pursuant to this Authorization, could be subject to re-disclosure by the recipient and, if so, may no longer be subject to federal or state law protecting its confidentiality;
- I may revoke this Authorization at any time (please see **Sentara Healthcare's** Notice of Privacy Practices for instructions on how to revoke); however, my revocation will not affect any action previously taken by **Sentara Healthcare** in reliance on this Authorization prior to receipt of my revocation; and
- Authorizing this disclosure is voluntary, I may refuse to sign this Authorization, and my treatment, payment, enrollment, and/or eligibility for benefits is not conditioned on me signing this Authorization.

Signature of Patient or Guardian/Legal Representative ______________________ Date ______________________

Authority or Relationship to Individual, if Representative ______________________

(7/2020)

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