

**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
2503 Robinhood Street, Suite 275
Houston, TX 77005
Phone: 713-529-0126 or 800-458-7870 Fax: 713-529-0780