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