



The APG Foundation  
P.O. Box 1248 • Cedar Rapids, IA, 52406-1248  
319-521-9596 • [apgfoundation.org](http://apgfoundation.org)  
Email: [info@apgfoundation.org](mailto:info@apgfoundation.org)

### Confirmation of Diagnosis Form

Instructions:

1. Form must be signed by patient in the presence of physician or authorized office personnel.
2. Form must be completed and signed by patient's attending physician or authorized office personnel.
3. Form must be accompanied by an APG Foundation Financial Assistance Application and submitted to The APG Foundation.

### Patient Authorization for Release of Information

I, \_\_\_\_\_, hereby authorize the release of the medical  
(Please print name)  
 information (as specified below) to The APG Foundation as confirmation of my cancer or blood disease diagnosis. This information will be used exclusively to determine eligibility for assistance by The APG Foundation for my benefit.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*Physician only below this line*

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### Physician Confirmation of Diagnosis

Patient Diagnosis:

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**Physician's Name (Please print):** \_\_\_\_\_

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(or authorized office personnel)

**Telephone:** \_\_\_\_\_

**Please attach to APG Foundation Medical Assistance Application Form and mail to**  
 APG Foundation, PO Box 1248, Cedar Rapids, IA 52406-1248  
**OR**, scan completed forms and email to [info@apgfoundation.org](mailto:info@apgfoundation.org)