



CONSENT FOR SERVICES

In signing below, I understand the information supplied for the intake form will be kept confidential. However, in order to provide me (or my dependents) with benefits and services from Cancer Services of Northeast Indiana (CSNI), I authorize the release of limited confidential information to those who may need it to help me (or my dependents), including, but not limited to, pharmacists, transportation agents, insurance companies, and my (or my child's) physician. I also authorize release of information to Cancer Services of Northeast Indiana by my (or my dependents') physician, insurance companies, and other persons providing medical/psychological services to us. This permission is given for all services rendered within three years of the request by Cancer Services of Northeast Indiana. I understand that CSNI does not release names, addresses, or mailing lists to other agencies or businesses without my consent. I also understand that CSNI is required to release confidential information if: I am a danger to myself or others; or my dependent is a danger to himself/ herself or others; or, I or my minor dependent(s) are believed to be the victim(s) of a crime.

Client's Signature: _____ Date: _____