PATIENT LISTING FORM

Please provide the requested information below to aid the Florida Department of Health in responding to your cancer concern. Please include contact information. If completed by a person with authority to provide consent for a minor, deceased person, or person under guardianship or other incapacity, please complete Page 2. Note that each individual must complete their own form, which can be returned individually or as packet to the following address:

Division of Disease Control and Health Protection
Florida Department of Health in Manatee County
410 6th Ave E
Bradenton, FL 34208

First Name: _____ Middle Name: _____ Last Name: _____

Date of Birth: _____ SSN: _____ Gender: _____

Race: _____ Cancer Type: _____

Diagnosis Date: _____ Hospital/Physician of Diagnosis: _____

Smoking History (Y/N): _____ Occupation: _____

Family Cancer History: _____

_____

Years Attended Bayshore High School: _____ Name while attended: _____

Role at Bayshore High: ☐ Student ☐ Teacher/Faculty

I authorize the Florida Department of Health to use the patient identifiable information I have provided above to search the statewide cancer registry database and conduct appropriate analyses to respond to my cancer concern. I also authorize SDMC to release my student records to the Florida Department of Health in Manatee County. I authorize the disclosure of my personal health and medical record information, education records as per FERPA, and personal identifying information, including my Social Security Number, by and between the Florida Department of Health, its Manatee County Health Department, and the School District of Manatee County (SDMC), for the purposes of a health-related investigation/study. A copy of your photo id or notarized signature must be included for identity verification in order to protect your rights under FERPA.

_____ Date: _____
Signature of Patient (or Personal Representative)

Phone Number: _____ Email address: _____

☐ Photo identification attached. If not, please complete notarization (see page 2).

Notarized signature required if photo identification not provided

FOR AN ACKNOWLEDGEMENT IN AN INDIVIDUAL CAPACITY:

STATE OF FLORIDA
COUNTY OF _____

The foregoing instrument was acknowledged before me this _____day of _____, 20___, by (name of person acknowledging).

_____
(Signature of Notary Public-State of Florida)

(NOTARY SEAL) _____
(Name of Notary Typed, Printed, or Stamped)

Personally Known _____ OR Produced Identification _____

Type of Identification Produced _____

If completed by a person other than the patient, please indicate and attach authorizing support documents:

Authority to Sign for Patient:
- □ Parent of Minor Child
- □ Power of Attorney
- □ Representative of Deceased's Estate
- □ Representative of Incapacitated Adults