African American Breast Cancer Alliance
AABCA
SHARE - SUPPORT - SURVIVE

Participant Contact Patient Consent Form

Print or type

Name:

Address:

City and Zip:

Home, Cell Phone:

Email address:

Date of Birth:

Date of Diagnosis:

Breast Cancer Stage & Type:

Other Information:

As a breast cancer patient, I give consent for my medical care provider to share the above information with AABCA for the purpose of contacting me to discuss confidential information, one-to-one and AABCA group support program services.

Signed: *(May be signed by patient or healthcare provider obtaining consent)* Date

Referred by:

Title & Institution:

Phone number:

Please mail completed form to:
AABCA, Inc., PO Box 8981, Minneapolis, MN 55408
Or E-mail to: info@aabcainc.org

For more information about the African American Breast Cancer Alliance (AABCA) and its breast cancer survivor support program, please call **(612) 462-6813**.

Educating and supporting Black/African Americans in their journeys with breast cancer and survivorship.

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www.aabcainc.org