Participant Contact 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: ______________________________

I give consent for my medical care provider to share the above information with AABCA for the purpose of AABCA contacting me to discuss free, personalized information, one-to-one and group support.

Signed: ______________________________

(May be signed by patient or healthcare provider obtaining consent)

Referred by: ______________________________

Title & Institution: ______________________________

Phone number: ______________________________

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

For more information about the African American Breast Cancer Alliance and its breast cancer survivor support program, please call (612) 462-6813 or (612) 825-3675.

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

Established 1990 – AABCA, Inc is a nonprofit, 501(c)3, tax exempt organization

AABCA, Inc. – PO Box 8981, Minneapolis, MN 55408
www.aabcainc.org