



Milton Hershey School Alumni Cancer Care Application

Applicant Name _____ Date _____

Address: _____

City _____ State _____ Zip _____ Telephone _____

HIS/MHS Class of: _____ Spouse's Name _____

Email _____ Cell Phone _____

I, _____ certify that I have been diagnosed with cancer by a medical provider and that I have the following financial need (brief description):

I understand that I am voluntarily disclosing my cancer related information for consideration by the Cancer Care Committee (the "Committee") of the Milton Hershey School Alumni Association for the sole purpose of applying for a donation.

I agree that the Committee may contact me to verify my cancer diagnosis and financial need in order to evaluate my application.

I acknowledge that information disclosed pursuant to this application may be subject to re-disclosure by the recipient and no longer be protected by Subpart E of the Regulations promulgated by the U.S. Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") relating to the privacy of individually identifiable health information.

Dated: _____ Signed: _____

The Cancer Care Committee affirms that we will protect your personal information from unauthorized access and improper use or disclosure.