CANCER DATA REGISTRY OF IDAHO PATIENT REQUEST FORM

Mail Requests to: Cancer Data Registry of Idaho
P.O. Box 1278
Boise, ID 83701

INDIVIDUAL WHOSE INFORMATION YOU ARE REQUESTING

(*Required fields)

*Patient Name:

Patient Alias Name:

*Patient Social Security Number:

*Patient Date of Birth:

*Patient Date of Diagnosis:

*Type of Cancer:

*Patient Date of Death (if applicable):
CERTIFIED DEATH CERTIFICATE MUST BE ATTACHED (with raised seal)

*Patient Address at Diagnosis (provide county at a minimum):

REPRESENTATIVE CONTACT INFORMATION

Last Name:	First Name:	Middle Name:
Physical Address:	City/State:	Zip Code:
Mailing Address (if different):	City/State:	Zip Code:
Daytime Phone:	Email Address:	Please return all certified copies: Yes ☐ No ☐

WHAT IS YOUR RELATIONSHIP TO THE PATIENT:

☐ Self	☐ Conservator
☐ Parent	☐ Personal Representative/Executor
☐ Guardian	☐ Other (Please specify – spouse, son, daughter, etc.)
☐ Medical Power of Attorney	

NOTE: You must attach all LEGAL documentation to verify that you have legal authority to access the patient's records (Please refer to the CDRI Patient Record Request Check List).

IDENTIFYING INFORMATION REQUIRED

Copy of Identification Attached:
Type: ☐ Driver's License ☐ Identification Card ☐ Birth Certificate ☐ Passport

Address Verification Attached:
Type: ☐ Utility Bill ☐ Phone Bill ☐ Driver's License ☐ Other

IF NO IDENTIFICATION IS ATTACHED, YOUR SIGNATURE MUST BE NOTORIZED.

Notarized by_____

Date_____

Notary Public Number_____
UNOFFICAL UNLESS STAMPED BY NOTARY PUBLIC

I DECLARE UNDER THE PENALTY OF PERJURY THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT.

Representative Signature: Date: