



If you, a friend or
a loved one is facing a
brain tumor diagnosis,
You Are Not Alone.

As part of our mission, beHeadStrong is here to support brain tumor patients and caregivers in the Kansas City community. If you would like to register for support services, please complete the following steps:

1. Complete the registration form
2. Read and complete the HIPAA authorization form
3. Read and retain our Privacy Statement for your records
4. Mail the completed Registration form and HIPAA authorization

form to: beHeadStrong, Inc.
 PO Box 25525
 Overland Park, KS 66225
 OR
 Fax to 913-362-7422

Upon verification of your condition with your physician, a representative from beHeadStrong, Inc. will be in contact with you to discuss our available services. All services are subject to availability and quantities are limited. Please direct any questions to beHeadStrong, Inc. at (913) 314-2255.

Find compassion, support,
and services through
beHeadStrong,
an organization founded
by brain tumor patients
and caregivers.

For more information, call
913.314.CALL (2255),
or visit us online at
www.beHeadStrong.org.

*We're here
to help.*



Registration Form

First Name
Last Name
Parent/Guardian if minor
Address
Home Phone
Cell Phone
e-mail
Contact preference
Physician Name
Physician Address
Physician Phone
Diagnosis
Date of Birth

Deuteronomy 31:6 "Be Strong and
courageous!"

www.beHeadStrong.org
501(c)3 organization—Tax ID# 71-0899918
P.O. Box 25525, Overland Park, KS 66225



Authorization for the Release of Health-Related Information
(HIPAA- Compliant Form)

Name of Patient (Please Print Name)

____/____/____
Date of Birth

I authorize _____ (attending physician) to disclose protected health information concerning me to beHeadStrong, Inc. By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and to confirm my condition as requested.

This protected health information is to be disclosed under this authorization so that beHeadStrong, Inc. may offer assistance in the form of :

1. Gift Certificates
2. Community Assistance as available

This authorization shall remain in force for twenty-six (26) months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to:

beHeadStrong, Inc.
P.O. Box 25525
Overland Park, KS 66225

I understand that a revocation is not effective to the extent that beHeadStrong, Inc. already relied on this authorization to disclose information about me. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but will not be re-disclosed by beHeadStrong, Inc. except as authorized by me or as required by law.

I understand that _____ (attending physician) may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my diagnosis, beHeadStrong, Inc. may not be able to process my application. I understand that any authorized representative or I will receive a copy of this authorization upon request.

Signature of Patient or Personal Representative

Date

____/____/____

Description of Personal Representative's Authority or Relationship to the Patient



PRIVACY NOTICE

beHeadStrong, Inc.
P.O. Box 25525
Overland Park, KS 66225

Protecting the privacy of information is important to us. This notice tells you how we treat information we receive from people who contact our organization.

We do not sell information about anyone to any person or organization. We maintain physical, electronic, and procedural safeguards to protect your privacy. Access to any personal information is limited to people who need to access the information to do their jobs.

We get most of the information we need from our applications and other forms. If a person authorizes it, we may get information from others such as an attending physician or clinic. We also get information as we process auction and donation transactions.

The information we may have includes items such as:

- Name
- Address
- Phone Number
- Medical diagnosis
- Donation history
- Purchase history

We use this information for business purposes such as:

- Fund raising
- Providing patient assistance

We will not share information with anyone else unless

- We have your permission
- We are allowed or required by law to disclose it.

We have the right to change our Privacy Policy. If we make a material change to our Privacy Policy, we will notify you before we put it into effect.