Please complete and email to: suzann@thedaviesproject.org
Mail to: The Davies Project, 230 Bingham St., Suite 100, Lansing, MI 48912
Fax to: 517-246-4944

Family Disclosure Authorization

I understand that only children with serious health conditions qualify for this service. Diagnoses that qualify for The Davies Project include, but **are not limited to,** any condition that requires pediatric specialty services, like cancer, diabetes, epilepsy, asthma, sickle cell anemia, mental illness, autism, developmental disorders, and many more. Likewise, the family must be facing a transportation barrier.

I, _____, hereby authorize, _____
(Family Name) (Clinic)

to disclose _____diagnosis of _____
(Print Patient's Name) (Print Patient's Qualifying Diagnosis)

to The Davies Project.

_____
(Family Signature)

Clinic Diagnosis Verification

I verify _____ is being seen/treated for the diagnosis/condition above.
(Print Patient's Name)

_____
(Clinic Representative Signature)

This patient will need help with transportation to the following types of appointments: _____
_____

Please give **The Davies Project** an idea of the time period (dates) during which this patient will need help:
_____