Referring Healthcare Professional Consent Form

By clicking the box below, I attest and agree to the following:

(a) I am the healthcare representative that is authorized to submit this application to the Humble Bumble Project (HBP) on behalf of the patient and the family.

(b) The patient or guardian, if under the age of 18, has given his or her consent to provide the information in this application, as well as consent to the release of medical and financial information, and has agreed to sign any additional forms and consents related to this application.

(c) The patient and family being referred understands that patients residing in the Tioga, Potter, or Lycoming Counties and being treated at Strong Memorial Hospital's James P. Wilmot Cancer Center, or Golisano Children's Hospital, or Geisinger Janet Weis Children's Hospital, or Geisinger Cancer Institute, will have priority.

(d) The information provided in this application is truthful and accurate. HBP shall be immediately notified if any information in this application changes, including the patient's or family's financial situation, insurance status, or the patient's medical condition.

(e) HBP will not be responsible or liable for any reason to the patient, the family, or the representative, regardless of whether or not HBP grants any funds to this applicant or any other applicant.

(f) If approved, HBP may provide travel assistance to eligible patients and their families. The program is limited by available resources and may be discontinued or changed at any time.

(g) I hereby give HBP my consent to use my information listed in this application and to contact me to discuss the information in this application and any related materials.

☐ **By checking this box, I agree to all the above.***

Your Full Name (Healthcare Representative)*

Today's Date

_____/_____/_____ (MM/DD/YY)

***Please email this consent form, the referral form, and the hive consent form to info@humblebumbleproject.com.**