Project Sol Flower Dream Fulfillment Program

Patient Information

- Project Sol Flower Applicant Name: _____
- Project Sol Flower Applicant Diagnosis: _____

Medical Information Authorization

I, the Project Sol Flower Applicant, grant Project Sol Flower permission to obtain any necessary medical information to evaluate and fulfill my bucket list dream request.
Additionally, I authorize all healthcare providers involved in my care to release such information to Project Sol Flower upon request. I agree to sign any additional medical authorization forms required to facilitate this process.

Project Sol Flower Applicant Signature: _____ Date: _____

Please send completed forms to DreamTeam@ProjectSolFlower.org and include the applicant name in the subject line.