

# The Molly Ann Tango Memorial Foundation Application for Assistance

The Molly Ann Tango Memorial Foundation is a 501(c)(3) not-for-profit organization which is committed to providing support to the families of children with special needs so that they may devote complete care and attention to the needs of their children.

Please send completed application to:

**The Molly Ann Tango Memorial Foundation**  
P.O. Box 15  
Ridgefield, CT 06877

*If you have questions, contact us at*

**Phone (203) 431-4180**

**Fax (203) 438-6716**

**Email: [info@mollytango.org](mailto:info@mollytango.org)**



For Office Use Only

Date Received: \_\_\_\_\_

File No: \_\_\_\_\_

**NOTE: All information will be kept strictly confidential**

Application Date: \_\_\_\_\_

Applicant's Name: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Male \_\_\_ Female \_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone \_\_\_\_\_

Child's Diagnosis:

Brief Description:

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Child's Date of Birth: \_\_\_\_\_

General Prognosis:

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**MEDICAL CONTACTS**

The following information is necessary so that we may verify your child's condition:

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Social Worker's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Physical Therapist's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_



**Authority to Release Hospital Record  
and/or Divulge Medical Information**

1. PRIMARY CARE PHYSICIAN/HOSPITAL

\_\_\_\_\_

Address: \_\_\_\_\_

In regard to your patient named: \_\_\_\_\_ DOB: \_\_\_\_\_

You are hereby authorized to furnish and release to The Molly Ann Tango Memorial Foundation all information and records requested (regarding findings, treatment rendered, and opinions) as to my child's condition. The foregoing authority shall continue in forces until revoked by me in writing.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

2. DOCTOR or NURSE/HOSPITAL

\_\_\_\_\_

Address: \_\_\_\_\_

In regard to your patient named: \_\_\_\_\_ DOB: \_\_\_\_\_

You are hereby authorized to furnish and release to The Molly Ann Tango Memorial Foundation all information and records requested (regarding findings, treatment rendered, and opinions) as to my child's condition. The foregoing authority shall continue in forces until revoked by me in writing.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

~~~~Please enclose a current photo of the child for whom this request is being made~~~~

### PHOTO RELEASE

The Molly Ann Tango Memorial Foundation may from time to time request to take and submit photos of your child/children to various publications for news-related stories about the Foundation and its related activities. We may also use such photos for promotional purposes, such as in advertisements, press releases, web site use, etc. Please indicate whether you would approve the use of your child's photo for such purposes by marking the appropriate spaces below:

I will allow my child's photo to be used for promotional or news-related purposes:

YES \_\_\_\_\_ NO \_\_\_\_\_

I will allow my child's name to appear in print for news-related purposes:

YES \_\_\_\_\_ NO \_\_\_\_\_

Child's Name \_\_\_\_\_

Parent's Name \_\_\_\_\_

**Parent Signature** \_\_\_\_\_

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