



HEREDITARY HEMOCHROMATOSIS DONATIONS ACKNOWLEDGEMENT

I understand that as a person with a diagnosis of hereditary hemochromatosis (HH), I am eligible for a program at Carter BloodCare that allows me to donate blood, which may contribute to the treatment of my condition, without payment for the procedure.

I understand that participation in this program does not depend on my ability to qualify for the volunteer donor pool. In other words, no matter what my health history answers are to the donor questionnaire, my blood will be drawn at no cost to me.

Printed Name: _____ Date of Birth: _____

Address:

Address City State Zip Code

Phone: _____ Email Address: _____
() _____
Area Code Phone Number

Please **Initial 1** of the Options Below:

_____ **Yes**, I would like my blood to be made available for transfusion to patients, if I meet all the current eligibility criteria. (I have reviewed the donor criteria pages and believe I qualify).

_____ **No**, I do not want my blood to be made available for use. (I understand I will still be drawn at no charge).

Signature Date

Please return completed form to:

Donor Notification Department
Email: DN@carterbloodcare.org
FAX: 817-412-5609

This form contains health information that is privileged and confidential, the disclosure of which is governed by federal and state laws. If you are not authorized to use or disclose this information, you are hereby notified that any use, dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this form in error, please notify Carter BloodCare at (817) 412-5603 immediately.