Authorization#:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Navigation #:      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Breast and Cervical Health Navigation Consent

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| **PROGRAM DESCRIPTION** |

The **Breast and Cervical Health Program (BCCHP)** is a joint effort between health providers, the Washington State Department of Health (DOH), and the Centers for Disease Control and Prevention (CDC) to support screening for breast and cervical cancer. The purpose of screening is to detect cancer in its earliest stage so that it can be prevented or more easily treated. BCCHP recognizes that there are barriers to receiving cancer screening that go beyond insurance coverage. The BCCHP program may be able to help some individuals obtain breast and/or cervical cancer screening tests by addressing possible barriers to cancer screening regardless of insurance status.

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| CONSENT FOR RELEASE OF INFORMATION |

I give consent to any and all of my medical and social service providers, clinics, hospitals, health insurance plans, and the BCCHP to provide each other with information about my health care and barriers to receiving care as it relates to addressing those barriers and completing cancer screening. I understand that this consent form expires 12 months after the date I sign this form. I must re-consent after 12 months to continue receiving navigation services.

**I understand that any information released to the BCCHP will remain confidential to the fullest extent permitted by law.** The information will be available to me, to the employees involved in my BCCHP services, the Health Care Authority (for the Breast and Cervical Cancer Treatment Program (BCCTP) if applicable), and to the Department of Health (the funding source of the BCCHP). The information will be used to meet the purposes of the BCCHP as described above. Published reports that result from the BCCHP will not identify any clients by name.

I understand that receiving navigation services is voluntary and that I may stop receiving services and withdraw my consent to release information at any time.

**If I falsify any information used to determine my eligibility, I understand that I am liable for the charges.**

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| Sign Your Name Here | Date |  | Witness: Health Facility | Date |
| Print Your Name Here |  |  | Interpreter (if used) | Date |