Washington State Department of Health
DOH 342-015 July 2020

SPOKANE REGIONAL HEALTH DISTRICT
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Breast, Cervical and Colon Health Program
Saving Lives Through Early Detection

Authorization#: ____________________ BCCHP#: ______________________

Breast, Cervical and Colon Health Program Consent

PROGRAM DESCRIPTION

The **Breast, Cervical and Colon 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 treated. Screening for breast cancer includes a breast exam and breast x-ray called a mammogram. Screening for cervical cancer includes a pelvic exam and taking a sample of cells from the cervix (opening of the uterus/womb) called a Pap and HPV test.

CONSENT FOR RELEASE OF INFORMATION

I give consent to any and all of my medical care providers, clinics, hospitals, health insurance plans, and the BCCHP to provide each other with information about my health care, cervical tests, breast exams, mammograms and any related medical care I receive through the BCCHP. I understand that this consent form expires 12 months after the date I sign this form. I must re-enroll after 12 months to continue services.

Any information released to the BCCHP will remain confidential. 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 being in this program is voluntary and that I may drop out of the BCCHP and withdraw my consent to release information at any time. I understand that if I am found to have breast and/or cervical cancer, I may be eligible to receive treatment through the Apple Health BCCTP. The BCCHP staff would then assist me in enrolling. As part of the Case Management services I receive, I understand I will be required to give my consent for treatment and provide other information as needed.

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

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