MS-BCCEDP INFORMED CONSENT/RELEASE OF INFORMATION CONSENT

Name: _____ **Date of birth:** ___/____/_____ **Social Security #**_____/_____ /_____
(Please Print) Last *First* *MI* *mm/dd/yyyy*

PROGRAM DESCRIPTION

The Mississippi Breast and Cervical Cancer Early Detection Program, MSBCCEDP, is a cooperative effort between facilities and providers, the Mississippi State Department of Health and the U.S. Centers for Disease Control and Prevention to encourage screening for breast and cervical cancer. The purpose of screening is to detect cancer in the earliest stage so that it can be treated. Screening for breast cancer involves a breast examination and a breast X-Ray called a mammogram. Screening for cervical cancer involves a pelvic examination and a scraping from the cervix (opening of the uterus) called a Pap smear.

- You will be able to receive an office visit, Pap smear and/or mammogram for FREE, if you meet the income eligibility requirements of the program and have no insurance or these services are not covered by your insurance.
- If your screening test result is abnormal, the facility/provider will work with the program to help you obtain further diagnostic tests and treatment. The program can pay for limited diagnostic services but cannot pay for treatment. Your health care provider can tell you which specific services can be paid for and which are not covered by the program. In the event that a breast biopsy is done and it is necessary to do further surgery for treatment purposes, the MSBCCEDP cannot pay for the treatment portion of the surgery, however, a referral will be made to the Mississippi Division of Medicaid for further financial assistance.
- In order to assure that adequate diagnostic and treatment services are available following abnormal screening results, the MSBCCEDP program and/or service provider may need to do an additional needs assessment with the patient in the form of case management.
- The facility/provider will work with you to let you know when you are due for your next Pap smear and/or mammogram.

CONSENT FOR SERVICES/RELEASE OF INFORMATION

I have read the above and understand the explanation about the Mississippi Breast and Cervical Cancer Early Detection Program and hereby consent to receive the health services as indicated. By agreeing to take part in this program, I give permission to any and all of my providers, facility, mammography facilities and/or hospitals to provide all information concerning my Pap smears, breast exams and mammograms and any related diagnostic procedures to the MSBCCEDP, which may include referral to clinical staff employed by the Mississippi State Department of Health.

Any information released to the program will remain confidential which means the information will be available only to me and the employees of the Mississippi State Department of Health working with this program. The information will be used only to meet the purposes of the program described above and any published reports that result from this program will not identify me by name.

I understand that my participation in this program is voluntary and that I may drop out of the program and withdraw my consent to release information at any time.

I understand that my ability to obtain screenings, payment, enrollment or determine my eligibility for care will not depend on whether I sign this authorization, except if the information is necessary to determine my enrollment or eligibility.

Privacy Notice:
I have received notice of my privacy rights and I have been given or offered a copy of the "Notice of Privacy Practices" by the Mississippi State Department of Health or your healthcare provider.

(Signature*): _____ ***Date:*** _____
mm/dd/yyyy

Signature of person giving consent: ☐ ***Self*** ☐ ***Authorized Legal Representative*** **Consent/Authorization will expire**
☐ **Two (2) years from date of diagnosis**

If not signed by the patient, please indicate your relationship to the Patient and attach any required documentation confirming your authority to act for the Patient: _____

Name: _____
(Please Print) Last ***First*** ***MI***

Provider or MD Name: _____

NOTE: FACILITY/PROVIDER MAY SUGGEST OR OFFER SERVICES WHICH ARE NOT PART OF MS-BCCEDP. IF YOU DECIDE TO USE THESE SERVICES, THEY WILL NOT BE REIMBURSED BY MS-BCCEDP

Mississippi Breast and Cervical Cancer Early Detection Program

CONSENT FOR SERVICES/RELEASE OF INFORMATION

FORM # 701

PURPOSE

To provide documentation of patients consent to voluntarily participate in the Mississippi Breast and Cervical Cancer Early Detection Program.

INSTRUCTIONS

All eligible patients must sign and date the Consent for Services/Release of Information form prior to the initial screening.

Patient Name: Enter the last name, first name and middle initial.

Date of Birth: Enter patient's date of birth using two-digit month, two-digit day, and four-digit month.

Social Security Number: Enter nine-digit number. If patient does not have SSN, enter 000-00-0000 in this area. **DO NOT LEAVE BLANK.**

Signature of person giving consent: Check the appropriate box.

Date: Enter date signed by the patient.

Consent/Authorization will expire two years from date of diagnosis.

If the person signing the form is not the patient, the relationship to the patient must be provided and attach any documentation confirming the authority to sign on the patient's behalf.

Patient's Name: Enter the last name, first name and middle initial.

Provider or MD Name: The name of the provider or the physician must be entered on this line.

OFFICE MECHANICS AND FILING

The original must be placed in the patient's record and a copy sent to the Breast and Cervical Cancer Program.

RETENTION PERIOD

This form becomes a part of the patient's medical record and is retained according to the retention requirements for this type of patient record.

NOTE: All patients returning for an annual re-screening must complete the consent form upon re-enrollment in the program.