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(Insert Agency Name Above or Place on Letterhead)

NC BREAST AND CERVICAL CANCER CONTROL PROGRAM
Consent for Services/Release of Medical Information

The NC Breast and Cervical Cancer Control Program (NC BCCCP) provides screening tests and/or limited diagnostic testing for breast and cervical cancer to eligible women ages 21-64. NC BCCCP may also provide screening and/or limited diagnostic testing **in special circumstances to women who present with symptoms under the age of 40** who meet eligibility criteria and whose diagnostic services are not otherwise covered through another program (for example, Title X Family Planning). In addition, NC BCCCP provides Patient Navigation-Only services for women who are diagnosed with breast or cervical cancer or breast or cervical pre-cancer outside of NC BCCCP. Patient Navigation-Only services are provided to assist with an application for Breast and Cervical Cancer Medicaid (BCCM).

____ I consent for NC BCCCP Screening/ Diagnostic Services
(Patient initials)

____ I consent for Patient Navigation-Only Services
(Patient initials)

I understand a screening may include one or more of these tests:

- Clinical breast exam.
- Pelvic exam with cervical cytology (ages 21-64 every three (3) years; of note, women ages 30 years and above may be screened every three (3) years with cervical cytology alone, every five (5) years with hrHPV testing alone, or every five (5) years with cervical cytology/hrHPV co-testing).
- Screening mammogram every 1-2 years after age 50 (or after age 40 if state funds are available).

I understand the program can only provide and pay for tests that are approved by the program. I understand that all results of the screening tests will be explained to me. If any test results are abnormal, I will be referred to another provider for more testing or treatment. All information will be kept private; only my doctor or nurse and the NC BCCCP staff can see it.

If further tests or surgeries are needed which are not covered by NC BCCCP, I understand I am responsible to work out a payment plan with my medical provider. I am responsible for keeping any appointments made for me. If I choose not to follow the program recommendations, treatment plan, or referrals to other providers, I accept full responsibility for the consequences of my decision.

I consent to planning of services to diagnose and treat problems found through NC BCCCP screening.

I authorize _____ (your agency's name) to send NC BCCCP test results to the provider of my choice and to NC BCCCP. I also authorize my physician or medical facility to release the diagnosis or findings pertaining to any breast and/or cervical cancer screening and/or diagnostic procedures to the _____ (your agency's name). The purpose of sending and receiving this information is to coordinate my care and provide information for statistical purposes.

DATE: _____ SIGNATURE: _____

WITNESS: _____