(Insert Agency Name Above or Place on Letterhead)

Breast and Cervical Cancer Control Program
Consent for Services/Release of Medical Information

The Breast and Cervical Cancer Control Program (BCCCP) provides screening tests and/or limited diagnostic testing for breast and cervical cancer to eligible women ages 21-64. 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 are not otherwise covered through another program (for example, Title X Family Planning).

I understand the screening will include one or more of these tests:

- breast exam
- pelvic exam with cervical cytology (ages 21-64 every 3 years; of note, women ages 30 years and above may be screened every 3 years with cervical cytology alone, every 5 years with hrHPV co-testing, or every 5 years with hrHPV testing alone)
- 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 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 the _____(your agency name) to send BCCCP test results to the provider of my choice and to the NC BCCCP. I also authorize my physician or medical facility to release the diagnosis or findings pertaining to any BCCCP screening referral to the _____(your agency name). The purpose of sending and receiving this information is to coordinate my care and provide screening information for statistical purposes.

DATE_____ SIGNATURE_____

WITNESS _____

DATE_____ SIGNATURE_____

WITNESS _____

DATE_____ SIGNATURE_____

WITNESS _____