Modify sections of the form below in bold, underlined, and in [ ] square brackets to meet your program's name and provisions

_____Health Department
Cancer Prevention, Education, Screening, and Treatment Program Consent Form

The Maryland Department of Health and Mental Hygiene ("DHMH") gives funds for the Cancer Prevention, Education, Screening, and Treatment Program from the Cigarette Restitution Fund (CRF) to the _____ Health Department CRF Cancer Screening and Treatment Program ("Cancer Program").

This is a consent form for the _____Health Department:

- **To get your medical information;**
- **To release your medical information;**
- **To help assess cancer screening services; and**
- **To provide cancer screening services, if indicated.**

You must read, and sign this form if you want the _____ Health Department Cancer Program:

- **To pay for your screening for [_____specify type] cancer;**
- **[To pay for diagnosis, and/or treatment and related services for _____ cancer]; and**
- **To assess the services you receive.**

_____ _____/_____/_____
Name **Date of Birth**

[I acknowledge that the _____Health Department Cancer Program has provided information to me about [colorectal/prostate/oral/skin] cancer screening. I agree to be screened.]

I authorize doctors and other medical providers (including hospitals and laboratories) to give results of my examination(s), laboratory test(s), biopsy(ies), hospital stay, and/or operation(s) related to cancer screening, diagnosis, and treatment to the _____ Health Department Cancer Program. I further authorize doctors and other medical providers to give to the _____ Health Department Cancer Program information from my medical history about **past** cancer screenings, diagnoses, and results.

I also authorize the _____ Health Department Cancer Program to share my information with the Maryland Department of Health and Mental Hygiene, Center for Cancer Surveillance and Control (DHMH) and the DHMH data contractor **[and add any other local subcontractors who will get the data]** and other DHMH-sponsored Cancer Programs for quality assurance, quality control, and other program management purposes. I understand that all information given to the _____ Health Department Cancer Screening and Treatment Program and to the DHMH is to help me get good medical care.

Name: _____

I understand that if I am part of the _____ Health Department Cancer Program, it does not mean that the _____ Health Department is going to be my primary doctor or health care provider.

Except for the release of information that I have authorized in this consent form, all information given to the _____ Health Department, to DHMH and its data contractor, and to DHMH-sponsored Cancer Programs will be kept **confidential** and will not be disclosed again to others except as allowed or required by Maryland or Federal law.

My medical information lets the _____ Health Department, and DHMH:

- make sure I get the right cancer screening, diagnosis, and treatment services;
- check on the services I get; and
- use data about my screening and treatment to manage and evaluate the program.

I also let the _____ Health Department Cancer Program give my records to my private doctor or to another doctor or medical provider if needed for my screening or medical care, or to give them to another DHMH-sponsored Cancer Program in Maryland if I move and ask for services in another county.

I know that I can ask for a copy of my records. I agree that this consent for obtaining and sharing medical records will be in effect as long as I am enrolled in the CRF Cancer Program. I agree that DHMH may share my medical information with another DHMH-sponsored Cancer Program in Maryland for as long as I am enrolled in one of the DHMH Cancer Programs. I can take back the consent at any time by writing to the _____ Health Department Cancer Program. I know that the information provided under this consent will be kept in a file for at least 12 years for the uses described in this consent.

I understand that the _____ Health Department Cancer Program may not be able to find a cancer even if I have one. [I understand that the _____ Health Department <u>will</u> pay for future visits, tests, and procedures to treat [_____ specify type] cancer if I am eligible for these services to the extent of available funds. Eligibility is based on my family income and whether I have health insurance.] **OR** [I understand that if I am found to need more tests or treatment, the _____ Health Department <u>will not</u> be able to pay for these tests and treatment; doctors or hospital may bill me for further services.]

_____ _____
Signature Date

_____ _____
Witness Date