Patient Name:________________________
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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 access case management services and patient navigation services;**
- **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 provide case management services and patient navigation services;**
- **To pay for your screening for [_________specify type] cancer, if applicable;**
- **[To pay for diagnosis, and/or treatment and related services for _________ cancer, if applicable]; 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 also authorize doctors and other medical providers to provide this information to the _____________ Health Department Cancer Program until it is determined that the screening, diagnostic work-up and initiation of treatment (or cycle of services) has been completed even if I become eligible for Medicaid or other health insurance and the _________________ Health Department Cancer Program ceases paying for these services. 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.

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I also authorize the _______________ Health Department Cancer Program to share my information with the Maryland Department of Health and Mental Hygiene, Center for Cancer Prevention and Control (DHMH),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.

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 understand that for me to get the best medical screening and health care, the __________ Health Department Cancer Program may need to give my records to my private doctor or to another doctor or medical provider, or to another DHMH sponsored Cancer Program in Maryland if I move and ask for services in another county. By signing this consent form, I give my consent for this information to be provided as stated in this paragraph.

I understand that under the authority of Health-General § 13-1107 to administer the Program effectively, including making sure that services are provided to the right individual, the ____________ Health Department Cancer Program may ask me for my social security number (SSN). The Program uses my SSN: (1) as an identifier to make sure that the medical records from or to a doctor, laboratory, or hospital are really mine; and (2) to check whether or not I am enrolled in the Maryland Medical Assistance Program, which will pay for these screening services. I understand that I do *not* have to provide my SSN, and if I don't provide it, I can still get services under the Cancer Program as long as I meet the Program's eligibility requirements.

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/CPEST Program or for a period of one year, whichever is shorter. I can take back the consent at any time by writing to the _______________ [Local CRF/CPEST Program Awarded Facility Name]. 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.

Patient Name:________________________

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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 will 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 will not be able to pay for these tests and treatment; doctors or hospital may bill me for further services.]

____ _________________

Signature Date

____ _________________

Witness Date