Iowa Care for Yourself Program

IOWA Health and Human Services
Public Health

Informed Consent and Release of Medical Information

Program #: _____ **Client #:** _____ **Date of Birth:** ___/___/_____

Name: _____ **Home Phone:** (___) _____-_____
PLEASE PRINT

Cell Phone: (___) _____-_____

Address: _____
PLEASE PRINT ***STREET*** ***CITY*** ***STATE*** ***ZIP***

*** Read about program services on the back of this consent.**
*** Sign this consent to be part of the *Care for Yourself* – Breast and Cervical Screening (Limited) Program.**

1. I want to be a part of the Care for Yourself Program. This program screens individuals for breast and cervical cancer. To be a part of the program, I must:
   a. Be 21 years or older;
   b. Earn less than the program income guidelines; and
   c. Be under-insured or uninsured and not have Medicare Part B.

2. Being a part of this program is my choice, however once I enroll, I must complete all of the necessary screenings I am eligible for as recommended by the program. Prior to receiving screening services, I will inform the *Care for Yourself* staff if I no longer wish to be part of the *CFY* program and received *CFY* screening services.

Contact your local coordinator <u>right away</u> if you have any questions.

_____
(Local Coordinator Name)

_____
(Phone Number)

3. I have discussed with the program staff about how I will pay for tests or services that are not covered by the *Care for Yourself* Program.
4. I accept responsibility for following advice my health care provider may provide.
5. I give permission for my health care provider, laboratory, clinic, radiology unit and/or hospital to provide the *Care for Yourself* Program results of my breast and cervical cancer screening exams, and/or screening results, follow-up exams and treatment.
6. *Care for Yourself* will use my name, address, and other personal information to remind me of screening and follow- up exams, and to help me find treatment, if needed.
7. Please contact the person listed below, who does not live with me, if you cannot reach me with important information about my health.

Name: _____ **Phone:** (_____) _____-_____ **Relationship:** _____
PLEASE PRINT

Address: _____
STREET *CITY* *STATE* *ZIP*

I release this program and its employees and agents from any claims, demands, and actions related to my participation in *Care for Yourself.*

_____	_____	_____	_____
Client Signature	**Date**	**CFY Coordinator Signature**	**Date**

WHITE – Local Program File **YELLOW – Participant**

Care for Yourself can pay for:

- An office visit that includes appropriate/recommended breast and cervical cancer screening;
- Clinical Breast Exam;
- Pelvic Exam;
- Pap Test and/or HPV Testing as eligible and recommended by provider;
- Two blood pressure measurements collected during the same office visit;
- Height and weight;
- Tobacco cessation referral;
- Mammography, as eligible and recommended by provider;
- Limited breast and/or cervical diagnostic services, as recommended by provider; and
- Referral for pre-cancer and cancer treatment, as recommended by provider.

Care for Yourself <u>does not</u> pay for:

- Any services not related to breast and/or cervical cancer screening;
- Any cancer treatment;
  If I am diagnosed with breast or cervical pre-cancer or cancer, program staff or Medicaid staff will check my income to help me find the best treatment resources. I may be required to prove my identity, that I am a United States citizen or legal alien, and provide income tax statement or paycheck stubs to prove my income to the Department of Human Services.
- Other tests the doctor may order such as urine or blood tests;
- Exams I had before signing up for the program *(the date on the other side)*;
- Diagnostic services not listed above; and
- Inpatient hospital or treatment services. Treatment includes any medical or surgical services prescribed by a doctor or nurse.

HIPAA allows for disclosure of protected health information to public health authorities for public health activities.

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