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:
   - Be 21 years or older;
   - Earn less than program income guidelines; and
   - Have health insurance that pays for office visits, mammograms and Pap/HPV testing.

   The *CFY* Program will help me access breast or cervical cancer screening, diagnostic or treatment services by assisting me in navigating these services.
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 receive *CFY* screening services.
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.

Contact your local coordinator <u>right away</u> if you have any questions.	_____ (Local Coordinator Name) _____ (Phone Number)

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*

8) 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**

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

***Care for Yourself* helps participants with the services identified below:**

- 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* does not help participants with the services identified below:**

- 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;
- Diagnostic services not listed above; and
- Inpatient hospital or treatment services. Treatment includes any medical or surgical services prescribed by a doctor or nurse.