

ABCCEDP INFORMED CONSENT/RELEASE OF INFORMATION CONSENT

PROGRAM DESCRIPTION

The Alabama Breast and Cervical Cancer Early Detection Program, ABCCEDP, is a cooperative effort between clinics and doctors, the Alabama Department of Public Health and the U.S. Centers for Disease Control and Prevention to encourage screening for breast and cervical cancer. The purpose of screening is to detect cancer in the earliest stage so that it can be treated or cured. Screening for breast cancer involves a breast examination and a breast X-ray called a mammogram. Screening for cervical cancer involves a pelvic examination and a scraping from the cervix (opening of the uterus) called a Pap smear.

- You will be able to receive your clinic/doctor visit, Pap smear and/or mammogram for FREE, if you meet the income eligibility requirements of the program and have no insurance or these services are not covered fully by your insurance.
- If you have an abnormal screening test result, the clinic/doctor will work with the program to help you obtain further diagnostic tests and treatment. The program can pay for limited diagnostic services but cannot pay for treatment. Your health care provider at the clinic or doctor can tell you which specific services can be paid for and which are not covered by the program. In the event that a biopsy is done and it is necessary to do further surgery (at that time) for treatment purposes, the ABCCEDP cannot pay for the treatment portion of the surgery.
- In order to assure that adequate diagnostic and treatment services are available, following abnormal screening results, the ABCCEDP program and/or service provider may need to do additional needs evaluation and assessment with the patient in the form of case management.
- The program will work with this clinic/doctor to let you know when you are due for your next Pap smear and/or mammogram.

CONSENT FOR SERVICES/RELEASE INFORMATION

I have read the above and understand the explanation about the Alabama Breast and Cervical Cancer Early Detection Program and hereby consent to receive the health services as indicated. By agreeing to take part in this program, I give permission to any and all of my doctors, clinics, mammography facilities and/or hospitals to provide all information concerning my Pap smears, breast exams and mammograms and any related diagnostic treatment procedures to the ABCCEDP, which may include referral to case managers employed by the Alabama Department of Public Health.

Any information released to the program will remain confidential, which means that the information will be available only to me and the employees of the Alabama Department of Public Health working with this program. The information will be used only to meet the purposes of the program described above and any published reports which result from this program will not identify me by name.

I understand that my participation in this program is voluntary and that I may drop out of the program and withdraw my consent to release information at any time.

Privacy Notice:

I have received notice of my privacy rights and I have been given or offered a copy of the "Notice of Privacy Practices" by the Alabama Department of Public Health or your health care provider.

Signature _____ Clinic or MD Name _____

Name _____ Date _____
(Please Print) Last First MI

NOTE: CLINICS/DOCTORS MAY SUGGEST OR OFFER SERVICES WHICH ARE NOT PART OF ABCCEDP. IF YOU DECIDE TO USE THESE SERVICES, THEY WILL NOT BE PAID FOR BY ABCCEDP.

Alabama WISEWOMAN Informed Consent/Release of Information Consent

You may receive Alabama WISEWOMAN (WW) services if you are an ABCCEDP patient and are between the ages of 40-64. The Alabama WW Program's aim is to help you reduce your risk for developing cardiovascular disease and/or stroke. As a participant, you will receive screening tests to identify your cardiovascular disease risk factors and help in reducing or controlling them. Alabama WW tests include: 1) taking two blood pressure measurements, 2) taking a small amount of blood (this may cause you some minor discomfort) to check your fasting glucose (or A1C level if you have Diabetes) and your cholesterol/lipid levels, 3) taking your weight, height, your body mass index (BMI), and, if desired, your waist and hip measurements, and 4) you will be asked if you use tobacco products. You will also be asked health questions to determine if you are healthy enough to participate in physical activity*. You will then meet with a doctor or medical professional to discuss your clinical and blood test results. (*Note: It's important to follow your doctor's recommendations regarding any physical activity.)

- On the same day, if your blood pressure, glucose/A1C, or cholesterol/lipid levels are high or if you smoke, you will be referred to an Alabama WW Social Worker. The WW Social Worker will assist you with lifestyle changes designed to reduce your risk factors and will share with you a program called **Health Coaching** which is effective in improving cardiovascular health. The WW Social Worker will also assist you in accessing social services provided in the community.
- If your results are high, you may be asked to return to the clinic for a follow up office visit with your doctor and for a nutritional counseling session with a dietician, the cost of these visits are paid for by the Alabama WW Program. **Please note that your doctor may recommend additional office visits besides these two which may not be covered by Alabama WW.**
- If the risk factor screening results are normal, you will receive Alabama WW services again at your next annual ABCCEDP screening visit, in 12 to 18 months.

RISK OF USING E-MAIL: Information contained in email messages may be privileged and confidential. There is some risk that any protected health information contained in an email may be disclosed to, or intercepted by, unauthorized people. These include, but are not limited to, the following risks:

- a) The Health Insurance Portability and Accountability Act of 1996 recommends that any E-mail containing protected health information should be encrypted. The E-mails sent from Franklin Primary Health Care Center or the **Alabama Department of Public Health** are not encrypted, so E-mails may not be secure. Therefore, it is possible that the confidentiality of such communications may be breached by a third party.
- b) E-mail can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients
- c) E-mail senders can easily misaddress an E-mail
- d) E-mail can be intercepted, altered, forwarded, or used without authorization or detection
- e) E-mail can be used to introduce viruses into computer systems

Consent for Services/Release Information

I have read the above and understand the explanation about WISEWOMAN and hereby consent to receive the health services as indicated. I know that I have the right to revoke this permission at any time (except to the extent that action has already been taken).

I understand the risks associated with Email communications between me and _____ **Franklin Primary Health Care Center** staff OR _____ **Alabama Department of Public Health** staff. Any questions I may have had were answered. If I provide my E-mail below, I understand the risks, and give my consent for _____ **Franklin Primary Health Care Center** OR _____ **Alabama Department of Public Health** to communicate with me regarding my protected health information by E-mail. This consent will be reaffirmed or discontinued, at my choice, at each clinic visit.

Any information released to the program will remain confidential, which means that the information will be available only to me and the employees of the Alabama Department of Public Health working with this program. The information will be used only to meet the purposes of the program described above and any published reports which result from this program will not identify me by name. I hereby give permission to the Alabama WISEWOMAN Program to disclose information about me to social service or community agencies and health care providers for the limited purpose of consultation or referral. This permission may include the disclosure of information about my medical condition but does not include the release of the written medical record.

By signing below, I certify I have read and understand the above information and give consent to authorize one or more of the above-listed services for myself. _____ I understand that I may withdraw from the WISEWOMAN program at any time while continuing to receive screening services via ABCCEDP. Unless otherwise revoked, this authorization will expire 18 months from the date signed.

Patient Signature: _____

Date: ____/____/____

Phone # _____ Email Address _____

Franklin Primary Health Center Representative: _____ Date: ____/____/____

Alabama Department of Public Health Representative: _____ Date: ____/____/____

The clinic or your doctor may suggest or offer services which are not part of Alabama WISEWOMAN. If you decide to use these services, they will not be paid for by ABCCEDP.