Washington State Department of Health

Washington Breast & Cervical Health Program
Take Charge of Your Health!

WASHINGTON BREAST and CERVICAL HEALTH PROGRAM
CLIENT CONSENT FORM

PROGRAM DESCRIPTION

The **Washington Breast and Cervical Health Program (WBCHP)** is a joint effort between health providers, the Washington State Department of Health (DOH), and the U.S. Centers for Disease Control and Prevention (CDC) to support screening for breast and cervical cancer. The purpose of screening is to detect cancer in its earliest stage so that it can be treated or cured. Screening for breast cancer includes a breast exam and breast x-ray called a mammogram. Screening for cervical cancer includes a pelvic exam and taking a sample of cells from the cervix (opening of the uterus/womb) called a Pap test.

CONSENT FOR RELEASE OF INFORMATION

I give consent to any and all of my medical care providers, clinics, and/or hospitals, and the WBCHP to provide each other with information about my health care, Pap tests, breast exams, mammograms, and any related medical care I receive through the WBCHP. I understand that this consent form expires 12 months after the date I sign this form.

Any information released to the WBCHP will remain confidential. The information will be available to me, to the employees involved in my WBCHP services, the Department of Social and Health Services (DSHS) Health and Recovery Services Administration (HRSA), Breast and Cervical Cancer Treatment Program (as applicable), and to DOH, the funding source of the WBCHP. The information will be used to meet the purposes of the WBCHP as described above and any published reports that result from the WBCHP will not identify any clients by name.

I understand that being in this program is voluntary and that I may drop out of the WBCHP and withdraw my consent to release information at any time. I understand that if I am found to have breast and/or cervical cancer, I may be eligible to receive treatment through the Medicaid program. The WBCHP staff would then assist me in enrolling. As part of the Case Management services I receive, I understand I will be required to give my consent for treatment and provide other information as needed.

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Sign Your Name Here | Date

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Print Your Name Here

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Witness: Health Facility | Date

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Interpreter (if used) | Date

DISTRIBUTION: White – WBCHP Prime Contractor; Canary – Clinic/Provider; Pink – WBCHP Client