

MICHIGAN BREAST AND CERVICAL CANCER CONTROL PROGRAM (BCCCP)
RELEASE OF INFORMATION

(To be used for provider/clinic sites where no other release form is in standard use.)

I UNDERSTAND THAT:

- Any personal information obtained about me will be kept confidential
- Signing this form grants permission to share my information with those providers/agencies listed below.
- Only information about me that does not identify me will be used in grouped reports or for other scientific purposes concerned with controlling breast and cervical cancer.
- I may be asked some time in the next several years to answer questions about my breast or cervical health, or my experiences with this screening program. I understand I am not required to answer such questions. If I do, I do not have to identify myself.

I GIVE PERMISSION AND AGREE TO:

- Provide the BCCCP Agency with information about me, including my health history and reports of screening and diagnostic tests and procedures relating to breast or cervical cancer.
- Allow the BCCCP Agency to give information regarding my care to:
 - My physician/health care provider
 - Any consulting physician
 - Any clinic or hospital to which I may be referred
 - Any other individual designated by me
 - The Michigan Department of Community Health and other State Of Michigan departments.

I have been able to ask questions about this program and this form, and have been given answers to my questions. Based on my understanding of this screening and follow-up program, I wish to enroll. Southwest Michigan BCCCP Agency Phone number is toll free: 1-888-243-4087.

Signature of client

date

Signature of person obtaining informed consent

date

CONTENTS OF THIS FORM REMAIN IN EFFECT ONE YEAR FROM DATE SIGNED