Washington State Department of Health

Breast, Cervical and Colon Health Program
Saving Lives Through Early Detection

Breast, Cervical and Colon Health Program

PROGRAM DESCRIPTION

The **Breast, Cervical and Colon Heath Program (BCCHP)** 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, cervical and colon cancer. The purpose of screening is to detect cancer in its earliest stage so that it can be prevented or treated. 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. Screening for colon health includes a fecal occult blood test (FOBT) or a fecal immunochemical test (FIT), which test for blood in the stool. This process is done with a take home test, which once completed, is returned to the clinic/provider by the BCCHP client. Other tests include colonoscopy and flexible sigmoidoscopy.

CONSENT FOR RELEASE OF INFORMATION

I give consent to any and all of my medical care providers, clinics, and/or hospitals, and the BCCHP to provide each other with information about my health care, Pap tests, breast exams, mammograms, FOBT, FIT, colonoscopy, flexible sigmoidoscopy and any related medical care I receive through the BCCHP. I understand that this consent form expires 12 months after the date I sign this form, meaning that I must re-enroll after 12 months to continue services.

Any information released to the BCCHP will remain confidential. The information will be available to me, to the employees involved in my BCCHP 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 BCCHP. The information will be used to meet the purposes of the BCCHP as described above and any published reports that result from the BCCHP will not identify any clients by name.

I understand that being in this program is voluntary and that I may drop out of the BCCHP 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 Breast & Cervical Cancer Treatment Program. The BCCHP 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.

I understand that if I am found to have colon cancer, the BCCHP staff will assist me in finding treatment resources regardless of my ability to pay.

Sign Your Name Here	Date	Witness: Health Facility	Date
Print Your Name Here		Interpreter (if used)	Date

For persons with disabilities, this document is available on request in other formats. To submit a request, call 1-800-525-0127 (TDD/TTY 1-800-833-6388).

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