New York State Department of Health
Cancer Services Program
Your partner for cancer screening, support and information

Participant ID: _____
Contractor ID: _____
Fax Number: _____

CONSENT FOR CANCER SERVICES PROGRAM PARTICIPATION

About the Cancer Services Program (CSP)

The CSP is a New York State Department of Health (NYSDOH) program that works with contract administrators, and with doctors, nurses and other health care providers to offer free, age-appropriate, risk-based screening for breast cancer, cervical (opening of the womb) cancer, and colorectal (the colon and rectum) cancer. Screening tests can help find these cancers in early stages when they may be easier to treat. Sometimes, when these cancers are found and treated early, they can be cured. Contract administrators work with you, health care providers and the NYSDOH to provide the services described in this consent.

The Age-Appropriate, Risk-Based Screenings Offered by the CSP are:

- Mammograms and clinical breast exams for breast cancer
- Pap tests and pelvic exams for cervical cancer
- Take home fecal tests (FIT or FOBT) for colorectal cancer
- Screening colonoscopy for men and women at increased risk for colorectal cancer (this means they have a greater chance of getting colorectal cancer)

People Who Have Abnormal Screening Tests (the screening tests show they may have one of these cancers) May Also Have the Following Services from the CSP:

- Diagnostic tests: These are tests and exams that check to see if cancer is there.
- Case management: People help you get to the diagnostic tests by helping make appointments, finding a way to appointments, finding child care, and many other ways to make it easier to get to the important diagnostic test appointments.
- Help finding treatment if cancer is found.
- Help getting in the Medicaid Cancer Treatment Program if you meet the program eligibility (rules). The Medicaid Cancer Treatment Program offers full Medicaid insurance for people with breast, cervical, colorectal or prostate cancer who meet the program eligibility (rules).

Income and Insurance Eligibility

Free cancer screening by the CSP is only offered to women and men who meet income and health insurance eligibility (rules). Income eligibility means that the total amount of money earned by people living in your house must be below a certain amount for you to get free CSP services. CSP services are also offered to women and men who do not have health insurance (including Medicaid or other public insurance) or whose health insurance does not pay for cancer screenings. CSP services may also be offered to women and men who have health insurance, but cannot afford to pay the insurance co-pay, deductible, or spend down. The CSP contractor staff or health care provider will give you information about income and health insurance and talk to you about whether or not you meet these program rules.

New York State Department of Health
Cancer Services Program
Your partner for cancer screening, support and information

Participant ID: _____
Contractor ID: _____
Fax Number: _____

Signing this consent means that:

- I have read the program information on page 1 and have talked to a CSP contractor staff or provider and understand the services being offered to me by the CSP.
- I agree to be in this program and understand that by agreeing to be in this program, I give permission to the New York State Department of Health, contract administrators and health care providers, including doctors, clinics, and/or hospitals to release (share) information about me. I understand this information includes financial and insurance information and medical information about me and related to my breast, cervical and/or colorectal cancer screening, and any related diagnostic and treatment care I receive. I understand this information will be released (shared) to other health care providers, contract administrators, other staff, health care providers or agencies participating in the CSP and the New York State Department of Health for my health care, treatment and follow-up, and for case management, tracking and payment purposes.
- I understand that information about me and my medical information will be released only as allowed by this consent or as allowed or required by law.
- I understand that this consent is for CSP cancer screening and related diagnostic and treatment services and case management, as needed and as provided under the Cancer Services Program.
- I understand that I may choose not to have the services that are offered to me at any time.
- I understand that someone will contact me if I am found to have an abnormal screening test (my screening test shows that I may have cancer). Case management services are provided to help me to get the recommended diagnostic follow-up testing and treatment, if needed. I understand that case management services are provided at no cost to me and that I can choose not to have the service at any time.
- I understand that my healthcare provider may recommend tests or procedures that may not be paid for under this program.

Attestation of Eligibility

A CSP staff person or provider told me about the program services and eligibility requirements and answered any questions I had. By signing this consent, I attest that to the best of my knowledge, I understand this information and by checking the boxes below, the following is true. I understand that the CSP and the New York State Department of Health may verify (check) the information I have provided herein.

I meet the following income eligibility requirements (choose one):

☐ My household income is at or below 250% of the Federal Poverty Guideline (FPG).

☐ My household income is above 250% of the FPG, but I cannot afford cancer screening/s.

I meet the following insurance eligibility requirements (choose one):

☐ I do not have health insurance of any type (this includes Medicare, Medicaid, Family Health Plus, or other public or private insurance).

☐ My health insurance deductible, monthly spend down, or co-payment is too high and prevents me from getting cancer screening services or my health insurance does not provide coverage for cancer screening and/or diagnostics.

☐ I authorize information about my services to be left on my **answering machine/voicemail.**

☐ I authorize the CSP to send me reminder **text messages.**

Client Information and Signature

Client Name (Print) _____ DOB _____

Client Signature _____ Date _____

Contractor Witness (Signature) _____ Date _____

Onondaga County
Cancer Services Program
Your partner for cancer screening, support and information

Client ID Number: _____
Partnership Name: _____
Fax Number: _____

Patient Name: _____

Patient Address: _____

Date of Birth: _____ Phone: _____

S.S. # _____

Consent to Use of Disclose Health Information to Carry Out Treatment, Payment, or Health Care Operations

Your health information is confidential. State and federal laws restrict its use and disclosure.

By signing this consent form you authorize the Onondaga County Health Department to use and disclose your identifiable health information for treatment, payment, and health care operations.

This consent may be revoked by writing to the HIPAA Compliance Officer at the following address: **421 Montgomery Street- 9th Floor, Syracuse, NY 13202**. Consent may be revoked except to the extent that this organization has relied on it.

_____ _____
Signature of Patient/Client or Legal Representative Date

Acknowledgement of Receipt of Notice of Privacy Practices

Please check the box below stating that you have received and retained a copy of the Notice of Privacy Practices:

☐ I have received a copy of the Onondaga County Health Department's Notice of Privacy Practices.

For OCHC Use Only:

Acknowledgement Not Obtained: ☐ Refused ☐ Other Staff Initials: _____

Onondaga County Health Department

New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

Patient Name	Date of Birth
Other Names Used (e.g., Maiden Name):	

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow **Onondaga County Health Department** to obtain access to my medical records through the health information exchange organization called HealtheConnections. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. HealtheConnections is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit HealtheConnections website at http://healtheconnections.org/ .

My information may be accessed in the event of an emergency, unless I complete this form and check box #3, which states that I deny consent *even* in a medical emergency.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ **1. I GIVE CONSENT** for **Onondaga County Health Department** to access ALL of my electronic health information through HealtheConnections to provide health care services (including emergency care).

☐ **2. I DENY CONSENT EXCEPT IN A MEDICAL EMERGENCY** for **Onondaga County Health Department** to access my electronic health information through HealtheConnections.

☐ **3. I DENY CONSENT** for **Onondaga County Health Department** to access my electronic health information through HealtheConnections for any purpose, ***even*** *in a medical emergency*.

If I want to deny consent for all Provider Organizations and Health Plans participating in HealtheConnections to access my electronic health information through HealtheConnections, I may do so by visiting HealtheConnections website at http://healtheconnections.org/ or calling HealtheConnections at 315.671.2241 x5.

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Details about the information accessed through HealtheConnections and the consent process:

1. **How Your Information May be Used**. Your electronic health information will be used **only** for the following healthcare services:
   - **Treatment Services.** Provide you with medical treatment and related services.
   - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
   - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
   - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.

2. **What Types of Information about You Are Included**. If you give consent, the Provider Organization and/or Health Plan listed may access ALL of your electronic health information available through HealtheConnections. This includes information created before and after the date this form is signed. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may include sensitive health conditions, including but not limited to:

Alcohol or drug use problems	HIV/AIDS
Birth control and abortion (family planning)	Mental Health conditions
Genetic (inherited) diseases or tests	Sexually Transmitted diseases

   If you have received alcohol or drug abuse care, your record may include information related to your alcohol or drug abuse diagnoses, medications and dosages, lab tests, allergies, substance use history, trauma history, hospital discharges, employment, living situation and social supports, and health insurance claims history.

3. **Where Health Information About You Comes From**. Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from HealtheConnections. You can obtain an updated list at any time by checking HealtheConnections website at http://healtheconnections.org/ or by calling 315.671.2241 x5.

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one.

5. **Public Health and Organ Procurement Organization Access**. Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through HealtheConnections for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

6. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call the Provider Organization at:**315-435-2000**; or visit HealtheConnections website at http://healtheconnections.org/; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: *http://www.hhs.gov/ocr/privacy/hipaa/complaints/*.

7. **Re-disclosure of Information.** Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.

8. **Effective Period**. This Consent Form will remain in effect until the day you change your consent choice or until such time as HealtheConnections ceases operation. If HealtheConnections merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.

9. **Changing Your Consent Choice**. You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice. Organizations that access your health information through HealtheConnections while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.

10. **Copy of Form**. You are entitled to get a copy of this Consent Form**.**