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

Client name or CSP ID#: _____

Fax #: _____

CONSENT FOR CANCER SERVICES PROGRAM PARTICIPATION

About the Cancer Services Program (CSP)

The CSP is a New York State Department of Health (NYSDOH) program. The CSP works with doctors, nurses, and other health care providers to offer free screening for breast cancer, cervical cancer, and colorectal cancer (also called colon cancer). Screening tests can help find these cancers early when they may be easier to treat. In some cases, screening can find cancer before it starts. CSP staff will work with you, health care providers, and NYSDOH to provide the services described in this consent.

The CSP offers these screenings:

- Mammograms for breast cancer
- Pap tests and high-risk human papillomavirus tests for cervical cancer
- Take home stool tests (Fecal Immunochemical Test [FIT] or Fecal Occult Blood Test [FOBT]) for colorectal cancer
- Screening colonoscopy for people who have a greater chance of getting colorectal cancer

The CSP offers follow-up services for people who have abnormal screening tests. An abnormal test means someone may have cancer.

- Diagnostic tests: Tests that check to see if cancer is there or not there.
- Case management: Help with making appointments, finding transportation, finding childcare, and other support to make it easier to get diagnostic tests.
- Help finding treatment if cancer is found.
- Help getting in the Medicaid Cancer Treatment Program if you meet the program rules. This program provides full Medicaid for people with breast, cervical, colorectal, or prostate cancer.

Income and Insurance Eligibility

The CSP provides no cost cancer screening and follow-up services to people who do not have health insurance. If you have health insurance, but the cost of cancer screening is still too high, you may be able to receive CSP services. You must also meet certain income rules to be able to get CSP services. CSP staff or a health care provider will talk to you about these rules and whether or not you are eligible for CSP services.

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Signing this consent means that:

- I have read the program information on page 1. I have talked to a CSP contractor staff or provider, and I understand the services the CSP is offering me.
- I agree to be in this program. I understand that by agreeing to be in this program, I give permission to NYSDOH, CSP, and health care providers (including doctors, clinics, and hospitals) to share information about me. This information includes my financial, health insurance, and medical information related to my cancer screenings and any follow-up and treatment care I receive. I understand this information will be shared with other health care providers, CSP staff, agencies working with the CSP and NYSDOH. This information will be shared for health care and case management tracking and payment purposes.
- I understand that information about me and my medical information will be released only as allowed by me or required by law.
- I understand that this consent is for CSP cancer screening, related follow-up and treatment services, and case management, as needed and as provided under the CSP.
- I understand that I may choose not to have the services offered to me at any time.
- I understand that someone will contact me if I have an abnormal screening test (my screening test shows that I may have cancer). Case management services are provided to help me get recommended follow-up testing and treatment, if needed. I understand that there is no cost to me for case management services and that I can choose not to have the service at any time.
- I understand that my health care provider may recommend tests or procedures that may not be paid for under this program.

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Attestation of Eligibility

A CSP staff person or provider has told me about CSP services and eligibility rules. This person answered any questions I had. By signing this consent, I confirm that, to the best of my knowledge, I understand this information. By checking the boxes below, I confirm that, to the best of my knowledge, the information is true. I understand that the CSP and NYSDOH may check the information I have provided.

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.

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 give permission for messages to be left on my voicemail about my services.

☐ I do not give permission for messages to be left on my voicemail about my services.

☐ I give permission for text messages about my services to be sent to me.

☐ I do not give permission for text messages about my services to be sent to me.

Client Information and Signature

Client Name (Print): _____ DOB:_____

Client Signature: _____ Date: _____

Contractor received consent form via:
☐ in person ☐ mail ☐ email ☐ fax

Contractor Signature _____ Date Received _____

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

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**.**