Iowa Get Screened: Colorectal Cancer Program

Informed Consent and Release of Medical Information

Program #: _____ **Client #:** _____ **Date of Birth:** _____/_____/_____

Name: _____ **Home Phone:** (_____) _____-_____
PLEASE PRINT

Cell Phone: (_____) _____-_____

Address: _____
PLEASE PRINT ***STREET*** ***CITY*** ***STATE*** ***ZIP***

*** Read and sign this consent and release to show that you know what it means and agree to it.**
*** Read about program services on the back of this consent.**
*** Sign this consent to be part of the *Iowa Get Screened* Program.**

1) I want to be a part of the *Iowa Get Screened* Colorectal Cancer Program. This program screens men and women for colorectal cancer. To be a part of the program, I know I must be between the ages of 50-64, have no colorectal cancer symptoms, earn less than the set income guidelines and be uninsured or underinsured.
2) Being a part of this program is my choice. I can tell the *Iowa Get Screened* staff if I no longer want to be part of the program.

Please contact your local program staff <u>right away</u>
if you have any questions.
Staff name: _____ **Phone #:** _____

3) I have talked with the program staff about how I will pay for tests or services not covered by *Iowa Get Screened*.
4) I accept responsibility for following advice my health care provider may give me.
5) I give permission for my health care provider, laboratory, clinic, radiology unit and/or hospital to provide the *Iowa Get Screened* Program results of my colorectal screening exams, follow-up exams and treatment. This includes results for program services provided within one year of the date below.
6) *Iowa Get Screened* will use my name, address, and other personal information to remind me of screening or follow-up exams, and to help me find treatment.
7) *Iowa Get Screened* and the Centers for Disease Control and Prevention (CDC) may approve studies to help researchers learn about colorectal health. My name will not be used. My information will be combined with other participant's information before it is shared.
8) Please contact the person who is listed below, who does not live with me, if you cannot reach me with important information about my health.

Name: _____ Phone: (_____) _____-_____ Relationship: _____
PLEASE PRINT

Address: _____
STREET *CITY* *STATE* *ZIP*

9) I release this program and its employees and agents from any claims, demands, and actions related to my participation in *Iowa Get Screened*. This includes any claims related to a failure to detect or diagnose cancer, failure of treatment, or any acts or omissions related to diagnosis or treatment while I am part of the program.

_____ _____ _____ _____
Client Signature **Date** **Provider Signature** **Date**

WHITE – Local Program File **YELLOW – Participant**

HIPAA allows for disclosure of protected health information to public health authorities for public health activities.

Iowa Get Screened: Colorectal Cancer Program

Program Services

Iowa Get Screened can pay for:	
If I am an eligible participant between the ages of 50-64	Screening Tests and Procedures • Fecal Immunochemical Tests annually • Colonoscopy every 10 years, from last screen • Biopsy/polypectomy during a colonoscopy • Bowel preparation • Moderate sedation for colonoscopy • Office visit related to above tests Diagnostic follow-up services as recommended • Office visit related to screening and diagnostic tests • Total colon exam with either colonoscopy (preferred) or DCBE if medically prescribed by doctor • Biopsy/polypectomy during colonoscopy • Moderate sedation for colonoscopy • Bowel preparation • Pathology fees

Iowa Get Screened does not pay for:	
If I am an eligible participant between the ages of 50-64	• Screening tests requested at intervals sooner than are recommended by for national guidelines • CT Colonography (or virtual colonoscopy) as a primary screening test. • Computed Tomography Scans (CTs or CAT scans) requested for staging or other purposes. • Surgery or surgical staging, unless specifically required and approved by the program's MAB to provide a histological diagnosis of cancer. • Any treatment related to the diagnosis of colorectal cancer. • Any care or services for complications that result from screening or diagnostic tests provided by the program. • Evaluation of symptoms for clients who present for CRC screening but are found to have gastrointestinal symptoms. • Diagnostic services for clients who had an initial positive screening test performed outside of the program. • Management of medical conditions, including Inflammatory Bowel Disease (e.g., surveillance colonoscopies and medical therapy). • Genetic testing for clients who present with a history suggestive of a HNPCC or FAP. • Use of propofol as anesthesia during endoscopy, unless specifically required and approved by the program's MAB in cases where the client cannot be sedated with standard moderate sedation.