Release of Information

I Understand That:

- Any personal information obtained about me will be kept private and confidential.
- By signing this form, I authorize you to release confidential health information to the providers/agencies listed below.
- The following health information may be released*:* my name, my contact information, my insurance status, results of prior breast and/or cervical test results and BC3NP services needed.
- The purpose of this release of information is to facilitate possible enrollment into the Breast and Cervical Cancer Control and Navigation Program (BC3NP).
- I have the right to revoke this authorization, in writing, at any time.

I Give Permission and Agree To:

- Provide _____ [Agency Name] with information about me, including, but not limited to, my name and phone number.
- Allow the _____ [Agency Name] to give information regarding my breast and/or cervical screening and/or diagnostics to:
  - _____ [Agency Name]

    Breast and Cervical Cancer Control and Navigation Program (BC3NP)

    Attn: _____ [Main Contact Person]
    _____ [Address]
    _____ [City, State, ZIP]
    _____ [Phone]
    _____ [Fax]

  - Any other individual designated by me: (please specify): _____

I have been able to ask questions about the Breast and Cervical Cancer Control and Navigation Program (BC3NP) and this form and have been given answers to my questions. Based on my understanding of the information, I wish for _____ [Agency Name] to forward my information to _____ [Agency Name] for possible enrollment into the Breast and Cervical Cancer Control and Navigation Program (BC3NP).

_____

Signature of client Date

_____

Signature of person obtaining release of information Date

Client Information

Last Name: _____ **First Name**: _____

Phone Number: _____

Email: _____