Consent Statement:

By utilizing the Maine CDC Breast and Cervical Health Program, I agree to let the Program:

- Collect information about me and my breast and cervical cancer screenings, diagnosis and treatment, if necessary.
- Contact me to ask questions to help improve the Program and contact me to offer assistance in obtaining services.
- Contact my doctors for my screening and test results and contact me with my screening and test results.

All the information about me, my screenings, and tests is kept private and completely confidential. If you have any questions about the consent, please call 1-800-350-5180, TTY (Deaf or Hard of Hearing) Users: Dial 711 (Maine Relay).

The Maine CDC Breast and Cervical Health Program (the Program) collects information from all participants to receive funding from the federal government. Any information turned over to the Program will be treated confidentially in accordance with the provisions of 22 M. R. S. A §1711-C, which means the information will be used to meet the purposes of the Program and any published reports which result from this Program will not identify me by name. By agreeing to take part in the Maine CDC Breast and Cervical Health Program, I understand that I may be contacted to provide information to evaluate the Program and may be offered case management services. In addition, I give my permission for all my health care providers, clinics, hospitals, mammography facilities, labs, and/or health insurance providers to provide all information concerning my Pap smears, breast exams, mammograms, radiological or laboratory results and/or care and treatment related to the Program. Such information may include services covered by the Program and delivered up to three months prior to the date of enrollment. I understand that once I have had a Maine CDC Breast and cervical Health visit, the Program will be allowed to obtain medical information for all breast and/or cervical procedures, cancer screenings, diagnosis and treatment. I understand that I have a right to request a copy of my Program records pursuant to 22 M.R.S.A §1711-B and may request that amendments be made to any incorrect or incomplete information contained in my records if my request is submitted in writing. I understand that notifying me of test results is a very important purpose of this Program, and that all available resources may be used to notify me if I have an abnormal test result. I understand that my participation in the Program is voluntary and that I may drop out of the Program and withdraw my consent at any time.