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California Department of Public Health



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**CONSENT TO PARTICIPATE IN PROGRAM AND FOR USE AND DISCLOSURE OF HEALTH INFORMATION  
California Colon Cancer Control Program**

The California Department of Public Health is working with your primary care provider to fulfill the purposes of the California Colon Cancer Control Program to:

- Increase public awareness about the importance of regular colorectal cancer screening
- Help healthcare professionals provide and promote high-quality colorectal cancer screening
- Increase the number of men and women over age 50 screened for colorectal cancer

Your primary care clinic will provide all colorectal cancer screening and services and report the results of these tests to California Department of Public Health's California Colon Cancer Control Program. **Signing this Consent form means that you want to take part in the California Colon Cancer Control Program ("Program") for one year.** To take part in the Program next year, you must sign a new consent to participate. Your primary care provider will contact you when you need to be screened again. Your primary care provider will continue to care for you whether you take part in the Program or not.

To determine your eligibility for the Program, your primary care provider will collect or review personal information, such as: your name, address, date of birth, income, race/ethnicity, and some family and personal health history. Your primary care provider will give you your colorectal cancer screening results. Your primary care provider will keep your medical record on file.

Only the results of your screening and diagnostic tests, but not your personal health information, will be sent to the California Department of Public Health for use as described in the Notice of Privacy Practices. All information will be protected as described in the Department's Cancer Detection Section Notice of Privacy Practices that you are given with this Consent. You have the right to inspect or obtain a copy of records kept by the Cancer Detection Section regarding your health care, as described in the Notice of Privacy Practices.

You will receive a copy of this consent to keep. Please talk to your primary care provider if you have any questions.

I, \_\_\_\_\_ (print full legal name), have provided correct and complete information and agree to take part in the California Department of Public Health's California Colon Cancer Control Program. I also agree to let my medical information be used and disclosed as explained above and as described in the Notice of Privacy Practices. I understand that by signing this form, I agree to take part in the Program. I further understand that to take part in the program next year, I must sign a new consent to participate.

I have been informed by the California Department of Public Health's California Colon Cancer Control Program of its Notice of Privacy Practices containing a more complete description of the uses and disclosure of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this Consent. I understand that the California Department of Public Health's Cancer Detection Section has the right to change its Notice of Privacy Practices from time to time and that I may contact the Cancer Detection Section at any time at the address listed at the bottom of this Consent to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that the California Department of Public Health's Cancer Detection Section restrict how my health information is used or disclosed to carry out treatment, payment or health care operations. I also understand the California Department of Public Health's Cancer Detection Section is not required to agree to my requested restrictions, but if it does agree then it will be bound to abide by such restrictions.

I understand that I may withdraw this Consent in writing at any time to stop future use and disclosure of my information. My withdrawal of my consent will not stop or reverse uses or disclosures of my information by the Cancer Detection Section that happened before I withdrew my consent.

If I am signing this Consent on behalf of another person, it is because I am the legal guardian, parent, or agent under an active Power of Attorney for Health Care, and am legally authorized to sign this Consent on behalf of the other person.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date (mm/dd/yyyy)

I have received a copy of the Cancer Detection Section Notice of Privacy Practices.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date (mm/dd/yyyy)

COMPLETE ONLY IF WITNESS IS NECESSARY: I have read the information on this form to the patient whose name is listed above. I conclude, to the best of my knowledge and belief, that the patient understands the information, is willing to take part in the program, and agrees to the terms of this consent.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date (mm/dd/yyyy)