State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

EVERY WOMAN COUNTS PROGRAM
CONSENT TO PARTICIPATE IN PROGRAM AND PRIVACY STATEMENT

The Department of Health Care Services (Department) pays for some tests to detect breast and/or cervical cancer for women who are low income, uninsured or underinsured, and cannot pay for these services. Most women do **NOT** have cancer. For the few who do, finding the cancer early may save their lives. **Signing this form means that you want to take part in the Every Woman Counts program.** This consent is valid for one year. You must sign a new consent form for each year you take part in the EWC program. You can stop taking part in the program at any time.

To participate in the EWC program, you must provide your name, address, date of birth, income, and some health history. This information must be provided or you will not be allowed to participate. Other information, such as your social security number (if you have one) will be asked, but you do not have to provide it to be screened. The EWC program is authorized to collect and maintain the information provided by you when applying for this program under the California Revenue and Taxation Code, Section 30461.6, 42; United States Code 1501; and 45 Code of Federal Regulations, Sections 160-164. All information will be protected as described in the EWC program Notice of Privacy Practices (NPP), which you are being given with this consent. Your primary care provider (PCP) will provide you with your screening results. Your PCP will keep your medical record on file and will send medical data to the EWC program to request payment, to use for utilization of health care operations, research, and in some cases, for coordination of treatment. Information may be shared with other programs in the Department and other governmental agencies. Your PCP may also share your personal information with other health professionals to assist you in obtaining recommended services. Information may be disclosed when required by law, such as for workers' compensation purposes. You have the right to inspect or obtain a copy of records kept by the EWC program regarding your health care, as described in the NPP.

Your name will not be used in any report that is public. Your name, date of birth, address, and social security number may be shared with other participating providers in the program for purposes of avoiding duplication of enrollment.

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

I, User Name (please print your name) have provided correct and complete information and agree to take part in the Department's EWC program. I also agree to let my personal and medical facts be used, as explained above. I understand that by signing this form, I agree to take part in the EWC program for one year, and for participation in the EWC program next year, I must sign a new consent to participate.

✍ _____ 07/23/2022

Signature Date

I have received and read the Notice of Privacy Practices.

✍ _____ 07/23/2022

Signature Date

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.

✍ _____ 07/23/2022

Signature Date

Every Woman Counts
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