Women's Wellness Connection

WWC CONSENT

WOMEN'S WELLNESS connection
Connect. Get checked. Be well.

Colorado Department of Public Health and Environment

FOR CLINIC STAFF USE ONLY		
AGENCY #	CHART #	WWC #

PATIENT INSTRUCTIONS: Please read this page carefully before signing below.

LAST NAME	FIRST NAME	MIDDLE NAME	MAIDEN NAME
LAST 4 NUMBERS OF YOUR SOCIAL SECURITY NUMBER		DATE OF BIRTH	AGE

I understand that by being in Women's Wellness Connection (WWC), I agree to what is written on this form.

- I understand that WWC is a breast and cervical health program. WWC does not cover the costs of care that are not associated with the breast or cervix.
- WWC does not pay for some tests. WWC does not pay for ANY treatment. I have talked to someone from this clinic about what choices I have and understand that I may have to pay for some tests and treatment.
- WWC has rules about the age and income of the women that join the program. I have been honest about my age and my income. I do not have Medicaid or Medicare Part B. I do not have other health insurance that will pay for these tests or my health insurance has a high deductible that I cannot afford.
- All of the information I have given to the clinic is true as far as I know. If I tell the clinic something that is not true, I may not get these tests and I may have to pay for any tests that have already been done.
- My doctor, clinic, hospital, laboratory, and mammography center may share my information with: _____ (contract agency name) and the Women's Wellness Connection (WWC) a program run by the Colorado Department of Public Health and Environment.
- If I agree to be in this program, WWC will receive my information. This may include results, costs of medical tests, insurance, and other related information that is needed for treatment, payment, and to run this program. This clinic and WWC may look at my health records to get this information. WWC is very careful to keep my information private.
- I understand that I have the right to change my mind about being in WWC. If I change my mind, I will inform my healthcare provider in writing and I will be withdrawn from WWC only when the notice is received and logged. I understand that any information shared prior to my withdrawal shall be kept by WWC. This authorization expires in one year.
- WWC, who pays for the program, looks at the breast and cervical health information on the women in the program to help improve the health of all women. They also look at demographic information.
- I may get letters in the mail to remind me when it is time for me to go back to my doctor or clinic for tests or treatment.

When I sign this form, I am saying that I understand what this form says and that I agree to it. I also agree to be in this women's health program called Women's Wellness Connection.

_____ _____

SIGNATURE DATE

_____

NAME (PLEASE PRINT)