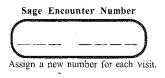
Sage Scopes Program Consent for Release of Information



Program. The Minnesota Department of Health (MDH) manages the Sage Scopes Colorectal Cancer Screening Program and the Sage Breast and Cervical Cancer Screening Program (collectively called "Sage Programs"). Sage Programs are funded by the Centers for Disease Control and Prevention (CDC) and the State of Minnesota.

Requirements to participate. You are not required by law to provide any information to the Sage Scopes Program. However, if you do not provide the requested information (except your social security number), you may not be able to participate in the program. While MDH requests your social security number in order to better identify your records, you may participate in the program even if you choose not to provide your social security number.

Scope of Consent. This Consent Form allows the Sage Programs to:

- Obtain your medical information from your health care providers
- Release your medical record information to CDC and its data contractor
- Assess cancer screening services through the program
- Remind you of medically appropriate screening opportunities

You must read and sign this consent form if you want Sage Programs to pay for your cancer screening.

I authorize doctors and other medical providers (including hospitals, endoscopy centers, and laboratories) to give the following information to the Sage Programs:

- All my identifying information, including my name, date of birth, address, phone numbers, health insurance, income, household size, race, ethnicity, place of birth, primary language, education, and social security number (if provided)
- Contact information for my doctors and health care providers, including their names, addresses and telephone numbers
- Medical information collected during the program, including my chart number; weight, height, blood pressure; tobacco use; colorectal medical history; results of colorectal cancer screening tests, symptoms, follow-up tests, and treatment
- Cost data related to procedures covered by the Program

All information released to the Sage Programs is protected by the Minnesota Government Practices Act. This means that the only people having access to my identifying information will be my doctors and health care providers and MDH employees who work with the Sage Programs or the Minnesota Cancer Surveillance System.

I authorize Sage Programs to share my information with doctors and health care providers whom I may involve in my medical care. Information released to doctors and health care providers is protected by federal or state medical privacy rules.

I also authorize Sage Programs to share my medical information, cost data, and demographics with CDC and its data contractor. Information released to CDC and its data contractor will **not** include my name, phone number, social security number, or address. If I need coverage for treatment, I authorize Sage Programs to release this information to the Minnesota Department of Human Services and its agents to assist me in finding and enrolling in a program that will cover treatment.

Except for the release of information that I have authorized in this consent form, all information given to Sage Scopes, CDC, and its data contractor will be kept confidential and will not be disclosed to others except as allowed or required by Minnesota or federal law. Sage Programs will use my information to:

- Document my eligibility for the program
- Assure that I receive appropriate preparation, screening, and diagnostic follow-up
- Assist in locating resources to support treatment (if needed)
- Manage and evaluate the program

I may withdraw from Sage Scopes and cancel the permissions authorized in this consent form prior to their expiration. In order to cancel my permission, I must send a letter to Sage Programs. The letter must include my name, date of birth, a statement cancelling my permission to release information, and my signature. If I cancel my permission, I will no longer be enrolled in Sage Scopes and may be financially responsible for any outstanding bills.

Name (printed):	Date of Birth:	_(mo)	(day)	(yr)
Signature:	Signature Date:	(mo)	_ (day)	(yr)

Note to health care providers: This document complies with the requirements of HIPAA (Health Insurance Portability and Accountability Act), the Federal Privacy Act of 1974, the Minnesota Government Data Practices Act, and the Minnesota Health Records Act, regarding authorizations to disclose protected health information. See 45 C.F.R. § 164.508(c) (1); 5 U.S.C. 55 Minn. Stat. §§ 13.05, subd. 4(d), 144.291 to 144.298.





Sage Scopes Program Enrollment Form Version 4

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4s	sign	a	new	num	ber	for	each	visit

version 4	· ·
1. Name: Last First Middle initial	2. Gender 🔟 Male 🖸 Female
3. Birthdate/	
month day year	
5. Street Address:	
6. City: 7. State:	8. Zip:
9. County: 10. Home phone #: ()	11. Other phone: ()
12. Are you Hispanic or Latino/a? (Mexican, South or Central American, Pue	erto Rican, Cuban, or other Spanish Culture)
13. What race do you consider yourself? (please check one or more of the fol	- ,
☐ White ☐ American Indian or A	laskan Native
2 Black or African American 3 Asian (specify)	Vietnamese, Korean, Cambodian, Chinese, Thai, Indian, or any other Asian)
□ Native Hawaiian or other Pacific Islander □ ou / v i	vietnamese, Rotean, Camboulan, Chinese, Thai, Indian, or any other Asian)
14. In what country were you born? United States Other	
15. What is the primary language spoken in your household?	
16. Do you have any health insurance? (Including Medical Assistance, Medic Yes, (please write the name of insurance)	,
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17. What is the total monthly household income before taxes? \$	per month business expenses).
18. Including yourself, how many people are supported by this income (check $\boxed{1}$ 1 $\boxed{2}$ 2 $\boxed{3}$ 3 $\boxed{4}$ 4 $\boxed{5}$ 5 $\boxed{6}$ 6 $\boxed{7}$ 7 $\boxed{8}$	cone box)? 1 8
19. Have you smoked cigarettes (tobacco) in the past 1 Week 2 Month 3 Year 4 More than a year	ago Never smoked
20. If you still smoke, would you like help quitting?	2 No
21. Does anyone else in your household smoke?	2 No
22. Please select your highest level of education.	
☐ Grade 8 or less ☐ Associate Degree	
☐ Grade 9-11 (some High School) ☐ Bachelor's Degree	(4-year college graduate)
☐ Grade 12 or GED (High School Graduate) ☐ Post-graduate degr	ree (Master's, Professional, Doctorate)
College or Tech. School, but no degree	
Patient Histor	•
(Please ask medical staff if you need assis	
23. Have you ever had a colorectal screening test? (Such as a Fecal Immunochemical Test (FIT), Fecal Occult Blood Test (FOB	T). Sigmoidoscopy, Colonoscopy)
a. If yes, what was your last test?Colonoscopy FIT/FC	DBT
b. When was your last test? Less than 1 year 1-4 years agc. Did your doctor recommend when you should be screened again?	
d. If yes, when did your doctor recommend that you be screened again?	
24. Do you have a history of colorectal cancer?	1 Yes 2 No 3 Don't Know
If yes, year of diagnosis: 25. Have you ever had precancerous polyps in your colon or your rectum?	Yes No Don't Know
23. Have you ever had precancerous polyps in your colon or your rectum?	☐ Yes ☐ No ☐ Don't Know
26. Has your mother, father, brother(s), sister(s), or children had:	Yes No Don't Know
a. Precancerous colorectal polyps before age 60?	1 2 3
b. Colorectal cancer before age 60?	1 2 3