Sage Encounter Number

_ _ _ _ _ _ _ _ _

Assign a new number for each visit.

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.

DEPARTMENT OF HEALTH

Please complete and return to:
Minnesota Department of Health
Cancer Control Section Sage Scopes Program
P.O. Box 64882, St. Paul, MN 55164-0882

SAGE MINNESOTA'S COLORECTAL CANCER SCREENING PROGRAM Scopes

Sage Encounter Number
_ _ _ _ _ _ _ _
Assign a new number for each visit.

Sage Scopes Program
Enrollment Form
Version 4

1. Name: _____ 2. Gender [1] Male [2] Female
Last First Middle initial

3. Birthdate _____/_____/_____ 4. Social Security #:_____
month day year

5. Street Address: _____ Apartment: _____

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, Puerto Rican, Cuban, or other Spanish Culture)
[1] Yes [2] No

13. What race do you consider yourself? (please check one or more of the following that identifies your race)

[1] White
[2] Black or African American
[3] Native Hawaiian or other Pacific Islander
[4] American Indian or Alaskan Native
[5] Asian (specify)_____
(Hmong, Vietnamese, Korean, Cambodian, Chinese, Thai, Indian, or any other Asian)
[6] Other (specify)_____

14. In what country were you born? [1] United States [2] Other _____

15. What is the primary language spoken in your household? _____

16. Do you have any health insurance? (Including Medical Assistance, Medicare, Minnesota Care, or private insurance?)
[1] Yes, (please write the name of insurance) _____ [2] No

17. What is the total **monthly** household income before taxes? $_____ per **month**
[Note: If you farm or are self-employed, use net income (after deducting business expenses).

18. Including yourself, how many people are supported by this income (check one box)?
[1] 1 [2] 2 [3] 3 [4] 4 [5] 5 [6] 6 [7] 7 [8] 8 [9] 9 [10] 10 or more

19. Have you smoked cigarettes (tobacco) in the past…
[1] Week [2] Month [3] Year [4] More than a year ago [5] Never smoked

20. If you still smoke, would you like help quitting? [1] Yes [2] No

21. Does anyone else in your household smoke? [1] Yes [2] No

22. Please select your highest level of education.

[1] Grade 8 or less
[2] Grade 9-11 (some High School)
[3] Grade 12 or GED (High School Graduate)
[4] College or Tech. School, but no degree
[5] Associate Degree
[6] Bachelor's Degree (4-year college graduate)
[7] Post-graduate degree (Master's, Professional, Doctorate)

Patient History

(Please ask medical staff if you need assistance with these questions)

23. Have you ever had a colorectal screening test? [1] Yes [2] No [3] Don't Know
(Such as a Fecal Immunochemical Test (FIT), Fecal Occult Blood Test (FOBT), Sigmoidoscopy, Colonoscopy)
a. If yes, what was your last test? _____Colonoscopy _____ FIT/FOBT
b. When was your last test? _____ Less than 1 year _____ 1-4 years ago _____ 5-9 years ago _____ 10 or more years ago
c. Did your doctor recommend when you should be screened again? ____Yes _____ No _____ Don't know
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? [1] Yes [2] No [3] 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]