COLORADO
Department of Health Care Policy & Financing

Colorado Medicaid's Breast and Cervical Cancer Program (BCCP)

Patient Contact and Consent Form (To be completed by clients diagnosed outside of WWC.)

Please enter your contact information below.

First Name: _____Middle Initial: __Last Name:_____

Date of Birth (MM/DD/YYYY): _____/_____/_____

Address:_____

Phone Number: _____

Please enter your health care provider's contact information below. (This is the same individual that provided you with a diagnosis.)

Provider's Name: _____

Provider's Address: _____

Provider's Phone Number: _____

Please print your full name in the consent statement and sign and date below.

I, _____, provide my consent to the Colorado Department of Health Care Policy and Financing's Breast and Cervical Cancer Program (BCCP) to share any information relating to the receipt of my BCCP application and my cancer diagnosis with the Women's Wellness Connection (WWC) program at the Colorado Department of Public Health and Environment.

Signature_____Date_____

Please submit this form as part of your completed BCCP Medicaid application.