



Consent for Enrollment and Release of Medical Information

MCN Health Network

I, _____, have been informed about MCN's Health Network.
(Please print participant's name)

The Health Network is made up of four projects called Track II, TBNet, CAN-track, and Pre-Natal. I understand that MCN does not provide any health care treatment in connection with these projects. I agree to participate in the Health Network, and I understand that my protected health information and personal information will only be released for the purposes of my medical treatment, healthcare operations, payment, or pursuant to my authorization. **I agree to carry my enrollment card and/or portable record and to present it at future sites where I seek health care.** I understand that the records MCN holds for me may contain sensitive health information (examples: HIV status and/or information about mental health issues) if my health care provider believes this information is needed for my continued treatment. I therefore consent to enroll in the following MCN Health Network project(s):

Please **only** select projects for health conditions for which you are receiving care and would like additional help. By checking these boxes you are authorizing MCN to have access to your medical records in connection with these projects.

- | | |
|---|---|
| <input type="checkbox"/> Tuberculosis (TBNet) | <input type="checkbox"/> Breast, Cervical or Colon Cancer (CAN-track) |
| <input type="checkbox"/> Diabetes (Track II) | <input type="checkbox"/> Pregnancy (Pre-Natal) |

I authorize MCN and future health care providers to have access to those medical records that my health care providers feel are necessary for my medical treatment and/or continued screening.

Authorized individuals from MCN may contact me by phone, mail or in person regarding follow up and referral for my treatment for these conditions. These individuals will adhere to federally mandated confidentiality procedures. This consent form will remain in effect for two years from the date that I sign this form. I can also submit a written request to leave the projects I am enrolled in at any time. I also understand that I have a right to receive a copy of my medical records on file with MCN upon written request. I hereby release MCN, its employees, officers, directors, successors and assigns in so much as following this Authorization and to the extent they make a good faith effort in complying with the federal privacy regulations. **This agreement will be effective for 2 years (24 months) from the date signed.**

First Name

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Last Name

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Mother's Maiden Name

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Birth Date (Month / Day / Year)

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Participant Signature (or Signature of Legal Representative)

Date

Enrolling Clinic Name & Phone Number

Relationship of Legal Representative to patient

Date

Witness Signature

ID Number
(from front of enrollment card)

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Password
(chosen by participant, must be 4 numbers long)

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Security Question #1: What is your City of Birth?

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Security Question #2: What is your Father's First Name?

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