AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

NORTH DAKOTA DEPARTMENT OF HEALTH & HUMAN SERVICES
HEALTH PROMOTION & CHRONIC DISEASE PREVENTION
SFN 54044 (3-2024)

I authorize my health care provider(s) and *Women's Way* to disclose information about my breast exams, mammograms, pelvic exams, Pap tests, and any other related care covered by the program to the North Dakota Department of Health and Human Services and the National Breast and Cervical Cancer Early Detection Program, administered by the Centers for Disease Control and Prevention (CDC). The purpose of the disclosure is to measure the occurrence of breast and cervical cancers and cancer rates among women.

As part of my participation in *Women's Way,* I agree to disclose my social security number so that information about me will be accurately maintained, even if, for example, another client has the same name as I do. A Federal law published in 42 United States Code sec. 405(c)(2)(C)(i) permits *Women's Way* to require and use my social security number for the identification of its clients. This information and any information I provide will remain confidential.

Women's Way may use the information for data management and analysis to meet the purposes of *Women's Way* and to reimburse services as required by the *Women's Way* Third Party Administrator. Any published reports and studies that result from *Women's Way* will not identify me by name or social security number.

I understand that *Women's Way* may occasionally send information to me about re-enrolling, reminders about screening, screening events, or other public health programs. I understand that information disclosed under this authorization may be further disclosed by *Women's Way* and may no longer be protected by Federal or State law. If information is disclosed, all directly identifiable information such as name, address, telephone number, and social security number is removed.

I understand that my participation in *Women's Way* is voluntary. I may withdraw from the program and cancel my authorization by sending a written notice to the *Women's Way* office where I am currently enrolled. I understand this authorization is valid as long as I participate in *Women's Way*.

I understand that failure to disclose my social security number will not affect participation in *Women's Way* but may delay the intake process and completion of enrollment.

Name (Last, First, Middle Initial)	Date of Birth (MM/DD/YYYY)
Signature	Date