

# Arizona Breast and Cervical Cancer Treatment Program (BCCTP)

## Patient Contact and Consent Form

Please enter your contact information below.

**First Name:** \_\_\_\_\_ **Middle Initial:** \_\_\_\_\_

**Last Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Address:** \_\_\_\_\_

**Phone Number:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

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Please enter your health care provider's contact information below.

**Provider's Name:** \_\_\_\_\_

**Provider's Address:** \_\_\_\_\_

**Provider's Phone Number:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

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

I \_\_\_\_\_ provide my consent to the Arizona Health Care Cost Containment System's (AHCCCS) Breast and Cervical Cancer Treatment Program (BCCTP) to share any information relating to the receipt of my BCCTP application, my BCCTP application processing time, the final approval/disapproval status of my BCCTP application and the date treatment is started with the Well Woman HealthCheck Program at the Arizona Department of Health Services. I approve sharing all application packet information with the Arizona Cancer Registry.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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Please submit this form as part of your completed BCCTP application packet to the Well Woman HealthCheck Program via fax, mail or in-person.

**Fax:** (602) 542-7520 **OR**

**Mail/In-Person:**

150 N. 18th Ave., Suite 300  
Phoenix, AZ 85007

