HEALTH SCREENING PROGRAM
CONSENT AND AUTHORIZATION

Barcode

The purpose of this voluntary health screening program offered through your employer is to gather sufficient information about you so you can receive an informative Healics, Inc. Health Report. The report you will receive and the medical information shared among Bellin Health, Healics, Inc., and the lab will constitute protected health information as defined by the privacy regulations implementing the Health Insurance Portability and Accountability Act of 1996 (HIPAA Privacy Rule). Bellin Health and Healics, Inc. have executed confidentiality agreements and certifications as necessary to comply with the HIPAA Privacy Rule.

Name of Employer Sponsoring HRA:_____

Last Four Digits of Your Social Security Number (SSN*): XXX-XX-_____ Have you participated in a Healics health screening before? ( ) Yes ( ) No
**SSNs are kept confidential and used by Healics and the lab for identification purposes only and will not be used for report scorecards or mailings.*

Name (please print): _____ _____ _____
(Last Name) (First Name) (Middle Initial)

Mailing Address:_____

City:_____ State: _____ Zip:_____

Phone: ( )_____ ( ) Mobile ( ) Work ( ) Home

E-mail:_____ Best Way to Reach You: ( ) Phone Call ( ) Text ( ) E-mail

Gender: ( ) Male ( ) Female Date of Birth (Month/Day/Year): _____/_____/_____ Age: _____

Regarding the sponsor employer, are you the: ( ) employee ( ) employee's spouse ( ) retiree ( ) retiree's spouse ( ) other

If you are a spouse, what is the employee's name?_____ Last 4 of Employee's SSN: XXX-XX-_____

CONSENT TO HEALTH SCREENING BLOOD TESTS: I wish to participate in a voluntary Health Screening program sponsored by my employer or by my spouse's employer (the sponsoring employer). As part of that program, I hereby provide my consent to Bellin Health (and any provider working with Bellin Health on the health screening program, including, but not limited to, Healics, Inc., and/or Clinical Reference Lab) to take measurements, including my blood pressure, to draw blood samples from my arm and to analyze the blood sample and test results. I understand there are possible risks associated with taking blood pressure or drawing blood from my arm including, but not limited to, the risk of infection, discomfort and bruising. I understand that other, more remote risks may be involved, however the information I have received is sufficient for me to consent to the blood sample, testing, and analysis. The screening vendor is not responsible for such conditions or effects (for example, the screening vendor will not pay for a physician to visit to treat bruising). I understand that 1) the results from my blood test are preliminary only and do not mean I have a particular diagnosis, 2) the health screening is not intended to replace a full examination by my own primary care provider, and 3) I am responsible, if I choose, for sending copies of my health screening results to my personal physician and arranging any follow-up examination(s) deemed necessary by my primary care provider. I understand that the blood test results will be entered into and available through the Bellin Health electronic medical record system. I have read/had read to me the above. I have had the chance to talk about any questions and concerns, which were answered to my satisfaction. I understand and agree with the above. Dr. Brad Wozny will be the ordering provider for health screening lab tests. I understand that Healics and its vendors generally are required by law to maintain the confidentiality of the medical information I provide through the health screening. The medical information includes my biometric results and other information about the manifestation of a disease or disorder. Healics uses this information to provide services to me and / or my spouse, such as an analysis of certain health risk factors. Healics is restricted by privacy law in how my or my spouse's medical information can be used or disclosed. For example, the Genetic Information Nondiscrimination Act generally prohibits Healics from disclosing to my employer my spouse's genetic information (which generally includes his or her health status). Such spousal information generally cannot be made available to managers, supervisors or others at the employer who make employment decisions, or anyone else in the workplace. Healics has established privacy and security policies and procedures that discuss how my medical information will be properly held, used and disclosed. I knowingly and voluntarily provide my Consent.

_____ _____
Signature of health screening participant date/time Signature of Witness date/time

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH SCREENING INFORMATION: I understand that Bellin Health will be obtaining personal health information (PHI) from me as part of my voluntary participation in the Health Screening, including, but not limited to, the results of the measurements, blood pressure tests, and blood tests, and the information on my health questionnaire that I will be providing as part of the health screening process. I hereby authorize that all such information relating my Health Screening, including my PHI, may be used by Bellin Health (and the other health screening providers, such as Healics or Clinical Reference Lab, working with Bellin Health) to perform the health screening. I authorize such information to be disclosed by those parties to those vendors, including Healics, retained by Bellin Health or the sponsoring employer to process my Health Screening results and/or to provide health management services connected to the Health Screening Program. I understand that Bellin Health and all the vendors involved in the health screening process are required to maintain the privacy of my PHI except as I may specifically authorize**.** I authorize the release of my name as a health screening participant to the sponsoring employer for the purpose of creating a participant name list. In the event that the sponsoring employer offers an incentive or health management program related to the health screening lab values, scores, and/or nicotine results, I authorize the release of my lab values, scores, and/or nicotine results to the sponsoring employer or its designated agent to use in the incentive or health management program. I understand that no other PHI or other information resulting from the Health Screening will be shared with the sponsoring employer or with any other party not specifically authorized under this agreement. I understand the program including any possible consultation or follow-up is not a substitute for a full examination by my own physician. I accept responsibility for arranging any follow-up examinations that may be appropriate. I authorize Bellin Health to use my PHI for payment and health care operations and to send me targeted information, based upon my personal health profile, designed to assist me in lowering my health risks and accessing necessary health care services. I am agreeing that I have read, understand, and am voluntarily agreeing to all the terms outlined on this page and that no strikeouts or additional writing will be accepted on this authorization. I have had the opportunity to raise any questions or concerns with Bellin Health, or other health screening provider, which were answered to my satisfaction. I further agree, understand, and acknowledge the following:

- That this Authorization is meant to comply with all state and federal laws regulating the form and content of authorizations for disclosure of medical information, including but not limited to, the medical privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA).
- That I have a right to request access to all my medical records that are used or disclosed pursuant to this Authorization
- That a photocopy of this Authorization will be as valid as the original.
- That I may request a copy of this Authorization.
- That I may refuse to sign this Authorization. Refusal to sign the authorization means that I am no longer eligible to participate in the assessment process.
- That this authorization will stay in effect until revoked or superceded by another agreement.
- That I may revoke this authorization at any time in writing, I understand that the revocation will not affect actions taken by parties in reliance on this Authorization.
- That my rights to revoke may also be limited by any Notice of Privacy Practices provided to me by my health care providers pursuant to the Health Insurance Portability and Accountability Act (HIPAA) Privacy regulations.
- That I may contact the Bellin Health Privacy Offices at (920) 433-3595 for information on how to revoke my authorization,
- That disclosed PHI may be subject to redisclosure by the person receiving the PHI and privacy protections may be lost.
- That the person(s) and/or organization(s) listed above whom I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits (except as has been explained to me by the sponsoring employer) on my decision to sign this authorization.
- That I have been provided with a copy of Bellins Health's Notice of Privacy Practices.

I have read/had read to me the above. I have had the chance to talk about any questions and concerns, which were answered to my satisfaction. I understand and agree with the above.

_____ _____
Signature of health screening participant date/time Signature of Witness date/time

***Please answer the questions on the following pages. Bring the completed questionnaire to the health screening*. If your primary care provider has prescribed any medication, you must stay on that medication for the health screen. Screening facility: please scan the completed questionnaire to** screen_team@bellin.org Information will be stored on the Healics, Inc. Computer System Standard Form Version 4.01 6/2018 © Healics Inc.