AGNESIAN WORK & WELLNESS

VOLUNTARY HEALTH SCREEN AND CONSENT

The purpose of this voluntary health screen program offered through Agnesian Work & Wellness is to gather sufficient information about you so that you can receive an informative Health Risk Assessment ("HRA") Report. The purpose of the report is to give you tools to help you take charge of your health and voluntarily make positive lifestyle changes. The report you will receive and the medical information shared among Agnesian Work & Wellness and the wellness program will constitute protected health information as defined by the privacy regulations implementing the Health Insurance Portability and Accountability Act of 1996 (the "HIPAA Privacy Rule"). Agnesian Work & Wellness, the wellness program and your employer have executed confidentiality agreements as necessary to comply with HIPAA Privacy Rule.

PLEASE REVIEW:

- I wish to participate in this voluntary health-screening program. I hereby provide my consent to Agnesian Work & Wellness and any provider associated with Agnesian Work & Wellness to draw a blood sample that may or may not be tested for the following: total cholesterol (TC), HDL, LDL, TC/HDL ratio, nicotine, PSA, triglycerides and glucose. The test results will be maintained in Agnesian Work & Wellness.
- I understand that testing done in the program is NOT a substitute for an examination by my own physician, and I understand that I am responsible for arranging any follow-up care indicated by the program results.
- I consent to the use of my personal medical information for Agnesian wellness program activities only.

I ALSO UNDERSTAND AND ACKNOWLEDGE THE FOLLOWING:

- That this consent for participation in the health screening and for the release of results obtained in connection with the health screening is meant to comply with all state and federal laws for the disclosure of health information, including the HIPAA Privacy Rule.
- That I may refuse to sign this consent; however, such refusal will result only in me declining to participate in the health screening and will not affect the other payment and health care operations activities of the wellness program.
- That I have the right to request access to all medical records that are used or disclosed pursuant to this consent, as further described in the wellness program's Notice of Privacy Practices.
- That a photocopy of this consent will be valid as the original and that I can receive a copy of this consent at any time upon request.
- That I have the responsibility to seek further medical care for any abnormal lab results identified in this health screening which I will receive via U.S. mail.

Signature of Participant or Legal Guardian: _____ **Date:** _____

Name of employer sponsoring health screening: Grande Cheese Company _____

Please Print: _____
(Last Name) (First Name) (MI)

You are the: ❑ employee ❑ employee's spouse ❑ retiree ❑ retiree's spouse ❑ other of employer sponsoring

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home phone number: ( )_____ Date of Birth: _____/_____/_____ (Mo/Day/Yr) Age: _____

If spouse of employee, employee's legal name: _____ DOB: _____