

Notice of Privacy Practices: I acknowledge and understand that Health Solutions Services, Inc., a subsidiary of Interactive Health, will use and disclose my personal and health information to Blue Cross Blue Shield of Massachusetts (“BCBSMA”) for use in connection with wellness programs, to receive payment for the care it provides, and for other health care operations. I acknowledge that I have been given the opportunity to review BCBSMA’s Commitment to Confidentiality, located on the BCBSMA website, which outlines BCBSMA’s practices in the use/disclosure of personal and health information. Health Solutions Services is prohibited from using or disclosing such information, except as otherwise allowed by the BCBSMA Commitment to Confidentiality.

Transfer of Results. As indicated by my signature, I have elected, or declined to elect, that Health Solutions Services may disclose the medical information obtained from my participation in this voluntary wellness screening to BCBSMA. I understand that BCBSMA may use this information to identify opportunities to provide education regarding certain health risks, and may contact me to promote participation in health and disease management programs. I also understand that BCBSMA may inform my employer that I have participated in this screening, but the actual results will not be shared with my employer. I understand that I may take part in the screening regardless of my willingness to have my screening results transferred to BCBSMA.

I understand that the information disclosed under this authorization may be redisclosed by BCBSMA in accordance with the BCBSMA Commitment to Confidentiality, and to the extent information is released to a non-Covered Entity (e.g., in response to a lawful subpoena), it may no longer be protected by the privacy regulations under HIPAA. This authorization shall remain in force until the earlier of one (1) year from the date I sign it or such time as I revoke it, in writing, sent by certified mail, return receipt requested and postage prepaid to, Health Solutions Services, Inc., 11409 Cronhill Drive, Suite M, Owings Mills, MD 21117, Attn: HIPAA Privacy Officer. I understand that revoking this authorization will not have any effect on actions that Health Solutions Services took in reliance on this authorization before it received my notice of revocation.

I **CONSENT** TO TRANSFER OF RESULTS AND/OR FACT OF PARTICIPATION, and therefore, **may** be eligible for certain incentives (incentives such as earning points on the ahealthyme wellness portal).

I **DO NOT CONSENT** TO TRANSFER OF RESULTS AND/OR FACT OF PARTICIPATION, and therefore, **may not** be eligible for certain incentives (incentives such as earning points on the ahealthyme wellness portal); **I understand that I will NOT be able to earn points on the ahealthyme wellness portal)**

X _____
Participant Signature/Legal Guardian

Date

Print Name (Participant or Legal Guardian)



SECTION I: TO BE COMPLETED BY PARTICIPANT (PLEASE PRINT)

Name: _____ BCBSMA ID #: _____ Gender: M / F

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: () _____ DOB: _____

Email: _____

Signature: _____ Date: _____

SECTION II: TO BE COMPLETED BY YOUR PROVIDER

Screening Date: _____ Fasting (please circle): YES / NO

Height: _____ feet _____ inches Weight: _____ pounds Waist Circumference: _____ inches

Total Cholesterol: _____ mg/dl HDL: _____ Ratio Total/HDL: _____

Glucose Level: _____ mg/dl Blood Pressure: _____ / _____ mm/Hg

Body Fat %: _____ Body Mass Index (BMI): _____

Provider's Signature: _____

Date: _____

Provider's Name (please print): _____

Provider's Address: _____

Return this form by: e-mail (offsiteforms@interactivehealthinc.com), fax (410-356-6205) or mail (Interactive Health, Attn: Alternative Means, 11409 Cronhill Drive, Suite M, Owings Mills, MD 21117).

PLEASE PICK ONE METHOD FOR SUBMITTING YOUR RESULTS by 06/05/2018