Authorization to Release Biometric Screening Information

HealthFitness.

To participate in the **USAA Health Screening (Health Risk Assessment/HRA) Alternative Screening Program** and be eligible to receive Healthy Points, you and your health care provider must complete this entire form. If any items are left blank or unsigned by your health care provider, this form will be considered incomplete. Pay special attention to the items in red to confirm your form is processed correctly. This form may be submitted **beginning January 1, 2020** and **must be received by October 18, 2020.**

To be eligible for your incentive, return your completed form to **Health Fitness Corporation (HealthFitness)** via fax at 1-866-698-9924 or mail to 18325 Waterview Parkway, Suite B200, Dallas, TX 75252. Remember to keep a copy of this form as confirmation for your records. Please note: You are responsible for any fees for your doctor's visit, as well as any processing fees to complete the necessary paperwork.

Please fax single forms only. Multiple forms can cause errors and delays in processing. For questions on the Alternative Screening program, call HealthFitness at 1-800-670-4316.

PARTICIPANT INFORMATION: PARTICIPANT MUST COMPLETE THE INFORMATION BELOW

Employee ID #: ***Spouses:*** *Employee's ID # + your birthdate MMDD Example: 123450101*		**Full Name:**	
Date of Birth:		**Gender:**	☐ Male ☐ Female
Preferred Telephone Number:		**Email Address:**	

BY SUBMITTING THIS FORM TO HEALTHFITNESS (WHETHER OR NOT SIGNED BY YOU), YOU HEREBY CONSENT TO THE USE AND DISCLOSURE OF YOUR HEALTH INFORMATION AND GINA AUTHORIZATION AS DESCRIBED BELOW.

Use and Disclosure of Your Information:

HealthFitness treats personally identifiable health information as confidential. The information you provide to us on this form will be used to:

- Generate a personalized health report for you.
- Generate a summary report so that your employer can understand the overall health strengths and concerns of the group. Your individual responses cannot be identified in the summary report.
- Inform you about materials, programs and services that might be useful to you.

The information you provide may be disclosed to the following individuals or groups as appropriate (as determined at HealthFitness' sole discretion):

- Authorized HealthFitness employees;
- Authorized individuals working for your employer or other third parties to the extent reasonably necessary for us to operate employer-sponsored programs in which you participate, provided the receiving party agrees to maintain the confidentiality of your information and information is used only for the purposes noted;
- Assigned contractors, their agents and successors whom we use to support our business in connection with any program sponsored by your employer in which you participate, provided the receiving party agrees to maintain the confidentiality of your information and information is used only for the purposes noted;
- Vendors, contractors and other third parties authorized to provide services and/or programs for your employer's health management plan, provided the receiving party agrees to maintain the confidentiality of your information and information is used only for the purposes noted;
- Those involved with the sale, assignment or transfer of business to which the information you give is related, provided they sign appropriate confidentiality agreements that maintain the confidentiality of your information;
- Those with whom we are required to share your information by applicable law, court orders or government regulations; or
- Health care personnel for treatment purposes including, for example, emergency assistance personnel.
- ***By submitting this form, I am authorizing HealthFitness to send me communications via email. I agree and understand that these email communications may contain a limited amount of personal information about me, including health related information and/or about my participation in certain programs offered through HealthFitness and/or its agents. I understand that these email communications are not encrypted and whoever has access to the email address I provide may also be able to see this information. I acknowledge that email sent without encryption may present some privacy risk, and that HealthFitness is not responsible for the privacy or security of information I request be emailed to me.***

GINA Authorization:

DO NOT DISCLOSE OR INCLUDE ANY GENETIC INFORMATION AS PART OF YOUR PARTICIPATION IN THE WELLNESS PROGRAM OR ANY OF ITS ACTIVITIES. Genetic information includes:

- any family medical history;
- any information related to your own or a family member's genetic tests;
- any information related to your own or a family member's request for, or receipt of, genetic services, or the participation in clinical research that includes genetic services;
- the genetic information of a fetus carried by yourself or by a family member or the genetic information of any embryo legally held by yourself or a family member using an assisted reproductive technology; or
- any genetic diseases for which you believe you may be at risk.

An employer may offer participation in certain wellness program activities which collect health information, such as the completion of a health assessment or biometric screening, to an employee's family members. As part of their voluntary participation in such programs, a family member may provide information concerning their past or current health status and/or medical conditions. Such information may be used by the wellness program to provide the family member with information to help them understand their current and/or potential health risks or to offer the family member services through the wellness program. Under applicable federal law, information concerning the past or current health status and/or medical condition(s) of an employee's family member is considered genetic information of the employee. Family members include certain blood relatives like parents, grandparents and children. Spouses and adopted children are also considered to be family members for this purpose.

Any individually identifiable genetic information that is collected by the wellness program from a family member, as described above, will be provided only to the family member receiving the services and the health care professionals involved in providing those services, or as required by law. Further, such individually identifiable genetic information is only available for purposes of the health services offered as part of the wellness program and will not be disclosed to the employer except in aggregate terms.

Participant Initials: _____ As an employee or family member eligible to participate in the wellness program, I acknowledge and agree that I should not and will not disclose or include any genetic information, as described above, as part of my participation in the wellness program. Additionally, as a family member, I hereby acknowledge and agree that:

- my provision of my past or current health status, medical condition(s) or other health-related information is voluntarily, and
- to the extent any information that I provide about my past or current health status, medical condition(s) or other health-related information is deemed, under applicable law, to be the genetic information of the employee, I permit and authorize the receipt and collection of such information by the wellness program.

MEDICAL FACILITY INFORMATION: PARTICIPANT MUST COMPLETE AND SIGN THE INFORMATION BELOW

I hereby authorize the medical facility listed below to release biometric assessment data to HealthFitness.

Facility Name:		Telephone Number:	

Participant Signature:_____ **Date:**_____

BIOMETRIC ASSESSMENT: MEDICAL HEALTH CARE PROVIDER MUST COMPLETE AND SIGN THE INFORMATION BELOW

Was your patient fasting? This means s/he has NOT had anything to eat or drink other than water in the last 9-12 hours. Note: *If s/he has not fasted, s/he may still participate, however, some of the measurements may be affected.* ☐ Yes ☐ No

Height: *Inches* Weight: *Pounds* Waist: Total Cholesterol: HDL: LDL:

Triglycerides: Glucose: Blood Pressure: /

Medical Health Care Provider Name (Please Print):_____

Medical Health Care Provider Signature:_____ Date:_____

INTERNAL USE ONLY: USAA