Authorization to Release Biometric Screening Information

HealthFitness.

Prospect Medical Holdings ALTERNATIVE MEANS SCREENING (AMS) PROCESS

Your form must be received on or before 8/1/2019. Please allow 10-15 days for processing.

Prospect Medical Holdings benefit enrolled employees who are unable to attend an on-site screening event, must use the "Alternative Means Screening Process" option provided by HealthFitness to qualify for the rewards requirement. We encourage you to take advantage of this opportunity to learn more about your current health status.

Please follow the instructions below to participate in your screening:

1. Call your medical health care provider for an appointment.*
2. Attend your appointment and make sure that you have the following measurements completed. For the most accurate results, you are encouraged to fast, which means consuming nothing but water, for 9-12 hours prior to your appointment. Please take all of your regular prescriptions as directed by your medical health care provider.

   - **Height (Inches)**
   - **Weight (Pounds)**
   - **Blood Pressure (mmHg)**
   - **Total Cholesterol (mg/dL)**
   - **LDL Cholesterol (mg/dL)**
   - **HDL Cholesterol (mg/dL)**
   - **Triglycerides (mg/dL)**
   - **Glucose (mg/dL)**

3. Ask your medical health care provider to complete the "Authorization to Release Biometric Screening Information" form (page 2).
4. Review your form carefully before submitting, as HealthFitness will process only those forms that have been fully completed.
5. Return your completed "Authorization to Release Biometric Screening Information" form to HealthFitness by 8/1/2019:

   a. **It is preferred that you log into your wellness website at https://pmh.biovia.healthfitness.com and upload your form from the Screenings link located under the MyHealth tab.**

   b. If you are unable to upload your form, please fax or mail your completed form to arrive no later than **8/1/2019** to **Health Fitness Corporation** at:

Fax Number: 1-866-698-9924

HealthFitness Corporation
18325 Waterview Parkway
Suite B200
Dallas, TX 75252

Please remember to keep a copy of the form as confirmation for your records.

****Note that it is the employee's responsibility to submit the form on time and it is highly recommended that the employee personally upload or fax the form. The physician office is not responsible for submission of the form, as this can cause submission deadlines to be missed and subsequent denial of AMS for failure to meet submission deadline. HealthFitness will send email confirmation when the form is received. ****

We hope that you take advantage of this great benefit. If you have any questions about this process, please contact HealthFitness Customer Service at 1-800-337-8508, option 1.

**Prospect Medical Holdings benefits enrolled employees who completed a health screening/blood work with their medical care provider on or after 1/1/2019 can have their provider complete the* "Authorization to Release Biometric Screening Information" *form and then fax or mail it in to HealthFitness - no additional screening is required.*

Your form must be received on or before 8/1/2019. Please allow 10-15 days for processing.

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To participate in **Prospect Medical Holdings** Alternative Screening program, 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. Please pay special attention to the items in red to confirm your form is processed correctly.

Please log into your wellness website at https://pmh.biovia.healthfitness.com and upload your form from the Screenings link located under the My Health tab. If you are unable to upload your form, please fax your completed form to **Health Fitness Corporation (HealthFitness)** at 1-866-698-9924 or mail to 18325 Waterview Parkway, Suite B200, Dallas, TX 75252. Please remember to keep a copy of this form as confirmation for your records. This form may be submitted **beginning 1/2/2019** and **must be received by 8/1/2019. Please allow 10-15 days for processing.**

Please upload or fax single forms only. Multiple forms can cause errors and delays in processing.

PARTICIPANT INFORMATION: PARTICIPANT MUST COMPLETE THE INFORMATION BELOW			
ID: Last 6 of SSN, MMDD of DOB & Gender (M, F, U)		**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 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.***

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:	*N/A*	Total Cholesterol:		HDL:		LDL:	
Triglycerides:		Glucose:		Blood Pressure:	/	A1C:	*optional*	Cotinine:	*N/A*		

Medical Health Care Provider Name (Please Print):_____

Medical Health Care Provider Signature:_____ Date:_____

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