AUTHORIZATION FOR DISCLOSURE OF PHI

University System of New Hampshire

I, the undersigned, represent as follows:

- I understand that my participation in this Biometric Health Screening is voluntary.
- I hereby authorize Health Solutions Services, Inc. (HSSI), a subsidiary of Interactive Health Solutions, Inc. (IH) and which administers this Biometric Screening, and Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company, Cigna Onsite Health, Inc. and their affiliates, subsidiaries or agents to disclose the Protected Health Information (PHI) indicated below to the persons or entities specified on this form.

Description of Information to be Released, Entity or Person Authorized to Receive Information, Purpose for Release of Information:

My individually identifiable health information will not be shared with my Employer; however my Employer may be advised of the fact of my participation in the Biometric Health Screening for purposes of qualification for incentives offered by my Employer. In addition, if my Employer offers incentives related to "pass/fail" test results, my "pass/fail" test results may be disclosed to my Employer for those incentive purposes. Interactive Health may disclose my Biometric Health Screening test results to vendors engaged by my Employer or Employer sponsored group health plan including Connecticut General Life Insurance, Company, Cigna Health and Life Insurance Company, Cigna Onsite Health, Inc. and their affiliates and subsidiaries for purposes of determining my eligibility for an incentive related to this Biometric Health Screening, for health management and/or disease management services including data aggregation for program improvement purposes, and/or for purposes of population of my Personal Health Record available online and/or my Health Risk Assessment (HRA).

The importance of safeguarding individually identifiable health information is recognized and all organizations involved in this Biometric Health Screening are obligated to take reasonable steps to protect such information from unauthorized access or use.

Expiration of Authorization to Disclose PHI:

This authorization expires: the earlier of one year from the date of my signature below, or the reporting of the information as described in this Authorization. Cigna Plan members: I have the right to revoke this Authorization in writing by sending a written request to Interactive Health at 11409 Cronhill Drive, Suite M Owings Mills, MD 21117. Also, I can obtain a Change/Revoke form by calling Interactive Health at 1-800-711-8656. Non-CIGNA Plan members: I have the right to revoke this Authorization by calling 1-800-711-8656. Any revocation of this Authorization will not apply to any disclosure made by Cigna prior to Cigna's receipt of my revocation. The provision of treatment, payment enrollment or eligibility for benefits does not depend on whether I sign this Authorization. Information disclosed based on this Authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations.

Please sign and complete page two, the Physician Screening Form, attached.

Signature:_____ Date: _____

Physician Screening Form

University System of New Hampshire

SECTION I: *TO BE COMPLETED BY YOU* (PLEASE PRINT)

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

Address: _____

City:_____ State:_____ Zip: _____

Work Phone Number: ( ) _____ DOB: _____

Email:_____

I have read and understand the information that has been supplied to me concerning the authorization and disclosure of PHI. My signature authorizes the disclosure of my PHI information to Cigna.

Signature:_____ Date: _____

SECTION II: *TO BE COMPLETED BY YOUR PHYSICIAN*

Examination and Blood Work Date:_____/_____/_____

Height:_____feet_____inches Weight:_____pounds Waist Circumference:_____inches

Blood Pressure:_____/_____mm/Hg Pulse: _____

The blood work results below are ○ Fasting ○ Non-Fasting

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

Glucose Level:_____mg/dl Triglycerides:_____LDL Cholesterol: _____

Physician's Signature: _____

Physician's Name (please print): _____

Physician's Address: _____

_____

Physicals and blood work must be completed between ***January 1, 2018*** *and* ***November 16, 2018*** *for credit.*
Conditions of Participation: All participants must be 18 years of age or older.
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 November 16, 2018.

THIS FORM MUST BE COMPLETED IN ITS ENTIRETY.

Revised 9/14/2015