Premise Health™
Keep your edge.

# Treatment and Medication History Consent and Patient Acknowledgment of the Notice of Privacy practices and Consent to Use and Disclose Health Information

I consent to all necessary steps taken for examination, diagnosis and treatment. If at any time I have questions about my examination, diagnosis, or treatment, I will not proceed until my questions have been answered so that I am fully informed. I understand that giving the providers and nurses all relevant information is important to my proper diagnosis and treatment. I understand complete compliance with my provider's instructions is critical to the success of any treatment prescribed.

If required by law, I acknowledge that I was provided with an opportunity of a copy of the Premise Health Notice of Privacy Practices regarding uses and disclosures of information regarding me and my health ("Health Information"). I hereby consent to the use and disclosure of my health information, for the purposes and activities permitted under the federal privacy and state privacy laws, which are described in the Premise Health Notice of Privacy Practices.

I specifically authorize the release, to the fullest extent permitted by law, for treatment, payment or operations purposes as described in the Notice of Privacy Practices, of information regarding the results of any HIV/AIDS testing or treatment, mental health treatment and substance abuse treatment.

I authorize Premise Health to release my health information to my health plan or to a health and wellness provider approved by my health plan for purposes of advising me concerning appropriate measures to maintain or improve my health or any condition reflected in my records.

I authorize Premise Health to release information to my designated insurance plan for the purpose of health plan administration, including receiving or making payment for services rendered on my behalf. I understand a patient is responsible for all charges incurred, subject to contract and program rules, regardless of my insurance status. If it becomes necessary to send this account to collections, the patient will be responsible for all additional charges.

I have read and do understand the above information.

_____ _____
Patient/Personal Representative Signature Date

_____ _____
Patient/Participant Name (please print) Date of Birth

Relationship of Personal Representative (parent/legal guardian): _____

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FOR SITE USE ONLY
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:
_____ Patient did not sign or refused to sign
_____ Communication barriers prohibited obtaining the acknowledgement
_____ An emergency situation prevented us from obtaining acknowledgement
_____ Other (Please describe: _____)

Original 5/15

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## Health Screening and/or Testing Consent Form

**Health Center Name _____The Clinic_____**

I understand the purpose of this health screening and/or testing is not to treat injury or disease but to assist me in improving my health behaviors.

I understand that health screening(s) and/or test(s) are not meant to replace the care of my personal physician. Premise Health will use this information to counsel me on my health behaviors and may recommend that I follow up with a medical provider. I have been given an opportunity to have all of my questions about any health screening(s) and/or test(s) answered to my satisfaction prior to the screening(s) and/or test(s) being performed.

I understand that Premise Health will maintain medical records created as a result of my health screening(s) and/or test(s), as required by state law. Premise Health is committed to protecting and preserving the confidentiality and security of my medical records.

If required by law, I acknowledge that I was provided with an opportunity of a copy of the Premise Health Notice of Privacy Practices regarding uses and disclosures of information regarding me and my health ("Health Information").

I understand that, if I so request, I will be given a copy of the Notice of Privacy Practices statement regarding medical record security and confidentiality.

I further understand my results may be reviewed by Premise Health clinical staff for quality monitoring purposes.

I, the undersigned, authorize Premise Health personnel, to perform a finger stick or venipuncture to obtain blood for the following blood test(s):

□ Glucose

□ Lipid Panel

□ Other(s): _____

I, the undersigned, authorize Premise Health to perform body and blood pressure measurements.

I understand that no individually identifiable information regarding my results will be shared with my employer without my written consent; only de-identified, aggregate information will be used for the purpose of evaluating program effectiveness.

I have read the above paragraphs and I am satisfied that I understand them.

Participant

Name (print): _____ Date of Birth: _____

Signature: _____

# AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

1. I hereby authorize (give permission for) Premise Health to disclose (give out) the health information specified below from biometric screening.

2. This authorization permits Premise Health to use and/or disclose the following individually identifiable health information about me. I hereby acknowledge that Premise Health may disclose my name and other identifying information regarding my participation in this event to my employer to verify my eligibility to receive special employer sponsored benefits and/or rewards.

3. Information is to be disclosed to: Person/Agency: WEB MD Health Services Group, Inc.
Address: 2701 NW Vaughn St. Suite 700
City, State, Zip: Portland, Oregon 97210

4. The purpose of the disclosure is for my biometric screening. If requested by the patient, purpose may be listed as "at the request of the individual." The purpose(s) is/are provided so that I can make an informed decision whether to allow release of my information.

5. I understand that I have a right to revoke (take back) this authorization (permission) at any time. I understand that if I revoke this authorization, I must do so in writing and provide my written revocation to: Premise Health Privacy Officer, 5500 Maryland Way, Brentwood, TN 37027. I understand that the revocation will not apply to information that has already been released in response to this Authorization.

6. If not revoked (take back) before such time, this authorization (permission) **will expire three (3) years from the date below** unless otherwise noted. Otherwise, this authorization will expire on **[date]:** _____ or a defined event _____.

7. I understand that after the above information is disclosed, it may be re-disclosed (given out again) by the person or agency that received it, and the information may not be protected by federal privacy laws or regulations.

8. I understand that authorizing the use or disclosure of the information identified above is voluntary. Whether or not I sign this form is not required for receiving health care treatment, payment, enrollment or eligibility for benefits and participation in the biometric screening program.

9. Premise Health will not receive payment or other remuneration (anything of value) from a third party in exchange for using or disclosing your health information or protected health information.

10. I have a right to receive a signed copy of this authorization form.

Signed by patient/legal representative: _____

Print Name by patient/legal representative: _____

Date: _____ Date of Birth: _____

If signature not patient's, relation to patient: _____