**Ascension Medical Group – Ascension Wisconsin – Ascension Wisconsin Employer Solutions**
**HEALTH RISK ASSESSMENT CONSENT FORM**

By signing this consent and release, I agree to participate in Ascension Medical Group/Ascension Wisconsin Employer Solutions wellness program. As part of a Health Risk Assessment (HRA), I agree to permit Ascension Wisconsin, directly or through its affiliates, employees, subcontractors or agents, to complete the test and measurements for the wellness screening, such as lab results, biometrics, and tobacco usage. "Ascension Wisconsin" refers to all healthcare organizations wholly owned, controlled and/or managed indirectly or directly by Columbia St. Mary's, Inc., Ministry Health Care, Inc. or Wheaton Franciscan Healthcare – Southeast Wisconsin, Inc. or their successor organization.

I understand that the results of the wellness screening and the completion of my health questionnaire will be used as part of a HRA and result in the creation of a health risk profile about me. I understand that my HRA results may be provided securely to me through the internet or on paper. I understand that if certain risk factors are found, I may be contacted at the address and phone number I provided to my employer about participating in wellness programs to address those risk factors. I understand that the data derived from my HRA is preliminary and not a complete diagnosis and that I should consult with my personal primary care practitioner regarding my HRA results and any follow up care. I understand that participation in a wellness program will not be a substitute for a medical checkup and is not, by itself, a basis for making any decision about the need for medical care. Wellness programs are intended to be informative, educational, and cannot predict whether I might develop a particular disease.

I agree that if I see an Ascension Wisconsin physician or obtain medical services from an Ascension Wisconsin hospital or outpatient clinic, those Ascension Wisconsin providers will have access to the HRA data and my health risk profile. I understand that these Ascension Wisconsin medical providers may not be "In-Network" providers under my employer's health plan. I acknowledge receipt of the Ascension Wisconsin Notice of Privacy Practices that outlines the use of my health information. In addition, I understand that Ascension Wisconsin and agents of my employer's health plan (e.g. brokers, third party administrators, etc.) may use the de-identified results of my screening and my health risk profile to determine aggregated group health risk factor statistics. Along with the items outlined in the Notice of Privacy Practices, I further understand and agree that Ascension Wisconsin and my employer's health plan may use and release any health information obtained as a result of my participation in the HRA in the following ways: combining my health information with other individuals' health information to create and release de-identified, aggregated group health risk factor statistics; releasing my health information to Ascension Wisconsin and health professionals hired by my employer and its subcontractors, for each of them to contact me and follow up with me regarding any risk factors I may present; using my health information for research purposes to study the value of risk reduction and the maintenance of low risk behaviors; releasing the fact that I participated in the HRA and any wellness programs to my employer and its health plan; and releasing a list of the wellness programs in which I participated to an administrator at my employer for the calculation of the incentive credits and/or allowing a third party (including a payer) to calculate my reward and release the amount to my employer.

I hereby release Ascension Wisconsin and my employer from any liability in connection with sponsoring or conducting this HRA. My participation in the HRA, including the wellness screening is voluntary. I may revoke this consent and release at any time (except to the extent that anyone already has acted in reliance upon it) by giving written notice to N9642 County Road N Appleton, WI 54915. If not previously revoked, this consent for participation in the wellness screening and for the release of information is effective so long as my employer offers health risk assessment screenings or wellness programs. If a recipient of the health information is not governed by federal and state confidentiality laws, the health information disclosed as a result of this authorization may be re-disclosed by the recipient and no longer be protected by such laws.

This authorization is voluntary. A copy or facsimile of this document is as valid as the original. Employment, payment, enrollment, or eligibility for benefits will not be conditioned on obtaining this consent.

I, _____ CONSENT TO THE ABOVE _____

PRINT LEGAL NAME SIGNATURE

SIGNATURE DATE: _____ DATE OF BIRTH: _____

FEMALE ☐ MALE ☐ EMPLOYEE ☐ SPOUSE ☐ RETIREE ☐

HOME PHONE NUMBER: _____ EMAIL ADDRESS: _____

COMPANY: _____ LOCATION: _____