Notice of Privacy Practices: I acknowledge and understand that Berkshire Medical Center Inc. will use and disclose my personal and health information to Blue Cross Blue Shield of Massachusetts (“BCBSMA”) for use in connection with wellness programs, to receive payment for the care it provides, and for other health care operations. I acknowledge that I have been given the opportunity to review BCBSMA’s Commitment to Confidentiality, located on the BCBSMA website, which outlines BCBSMA’s practices in the use/disclosure of personal and health information. Berkshire Medical Center Inc. is prohibited from using or disclosing such information, except as otherwise allowed by the BCBSMA Commitment to Confidentiality.

Transfer of Results. As indicated by my signature, I have elected, or declined to elect, that Berkshire Medical Center Inc. may disclose the medical information obtained from my participation in this voluntary wellness screening to BCBSMA. I understand that BCBSMA may use this information to identify opportunities to provide education regarding certain health risks, and may contact me to promote participation in health and disease management programs. I also understand that BCBSMA may inform my employer that I have participated in this screening, but the actual results will not be shared with my employer. I understand that I may take part in the screening regardless of my willingness to have my screening results transferred to BCBSMA.

I understand that the information disclosed under this authorization may be redisclosed by BCBSMA in accordance with the BCBSMA Commitment to Confidentiality, and to the extent information is released to a non-Covered Entity (e.g., in response to a lawful subpoena), it may no longer be protected by the privacy regulations under HIPAA. This authorization shall remain in force until the earlier of one (1) year from the date I sign it or such time as I revoke it, in writing, sent by certified mail, return receipt requested and postage prepaid to, Berkshire Health Systems, Inc., Wellness at Work, 725 North St., Pittsfield, MA 01201, Attn: HIPAA Privacy Officer. I understand that revoking this authorization will not have any effect on actions that Health Solutions Services took in reliance on this authorization before it received my notice of revocation.

☐ I CONSENT TO TRANSFER OF RESULTS
AND/OR FACT OF PARTICIPATION and, therefore, may be eligible for certain incentives (incentives such as earning points on the ahealthyme wellness portal)

☐ I DO NOT CONSENT TO TRANSFER OF RESULTS
AND/OR FACT OF PARTICIPATION and, therefore, may not be eligible for certain incentives (I understand that I will NOT be able to earn points on the ahealthyme wellness portal).

X ______________________________
Participant Signature/Legal Guardian

______________________________
Date

______________________________
Print Name (Participant or Legal Guardian)

PLEASE REMEMBER TO SUBMIT BOTH PAGES!
WE CANNOT ACCEPT YOUR PHYSICIAN VERIFICATION FORM IF YOU DO NOT RETURN BOTH PAGES!
SECTION I: TO BE COMPLETED BY PARTICIPANT (PLEASE PRINT)

Name: ___________________________________________ BCBSMA ID #: ___________________ Gender: M / F
Address: _______________________________________________________________
City: ___________________________ State: ________ Zip: ___________
Phone Number: ( ) ___________ DOB: __________________________
Email: ___________________________________________________________

Signature: ___________________________ Date: _______________________

SECTION II: TO BE COMPLETED BY YOUR PROVIDER

Screening Date: ______________________ Fasting (please circle): YES / NO
Height: _______ feet _______ inches  Weight: _______ pounds  Waist Circumference: _______ inches
Total Cholesterol: _______ mg/dl  HDL: _______  Ratio Total/HDL: ___________
Glucose Level: _______ mg/dl  Blood Pressure: _____ / _____ mm/Hg

Body Fat %: ___________  Body Mass Index (BMI): ___________

Provider’s Signature ___________________________________________________________
Provider’s Name (please print): _______________________________________________
Provider’s Address: ___________________________________________________________________________

Please return BOTH pages of this form by: email (llaramy@bhs1.org); fax (413-395-7653); or mail (Berkshire Health Systems, Wellness at Work Dept., c/o Lisa Laramy, 165 Tor Ct., Pittsfield, MA 01201)

CHOOSE ONE METHOD FOR SUBMITTING YOUR RESULTS BY 9/30/17.
IT IS THE PARTICIPANT’S RESPONSIBILITY TO RETURN THIS FORM.

PLEASE REMEMBER TO SUBMIT BOTH PAGES! WE CANNOT ACCEPT YOUR PHYSICIAN VERIFICATION FORM IF YOU DO NOT RETURN BOTH PAGES