Preventive Exam Form

HealthAdvocate℠
Caring for you in all ways. Always.

To be completed by Employee, Spouse/Domestic Partner, or Dependent:

(Please Print)

Last Name: _____ First Name:_____

Company:_____ ZIP Code:_____ Employee ID#:_____ (required)

Choose One: Employee ☐ Spouse/Domestic Partner ☐ Dependent ☐

Last 4 SS#:_____ DOB:_____/_____/_____ Gender: Male ☐ Female ☐

(Month) (Day) (Year)

Email Address: _____

Phone: _____

By checking 'Agree', I agree to receive communications/texts from Health Advocate: Agree ☐

If for spouse/domestic partner, please list employee's name: _____

I authorize my healthcare provider to release the requested information to Health Advocate.

Signature:_____ Date: _____/_____/_____

Do not write below this line

To Be Completed by Provider's Office

Please check the box appropriate to the exam performed between **October 1, 2026** and submit by **September 30, 2027.**

Submit a separate form for each exam/screening completed.

☐ Annual Physical Exam	☐ Flu Shot	☐ Skin Cancer Screening
☐ Breast Cancer Screening	☐ Osteoporosis Screening	☐ Vision Exam
☐ Cervical Cancer Screening	☐ Preventive Dental Visit	☐ Diabetes Screening
☐ Colon Cancer Screening	☐ Prostate Cancer Screening	☐ Cholesterol Screening

_____/_____/_____ **DATE OF EXAM**

_____	_____	_____/_____/_____
Healthcare Provider/Verifier Signature	Office Telephone Number	Signature Date

Please fax this document to Health Advocate at 1.610.397.7891 or email it to biometricforms@healthadvocate.com.

IT IS PREFERRED THAT THE FORM BE FAXED OR EMAILED FROM A PHYSICIAN'S OFFICE, BUT NOT MANDATORY.

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Preventive Exam
Notice & Authorization Form

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Exam date and type may be verified with physician's office.

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Important Information

The purpose of this Notice and Authorization Form relates to screening for cholesterol, glucose, blood pressure and/or body composition measurements as part of an employee wellness program. By participating, you hereby release the administrators of the screenings, Health Advocate, the employer and/or its group health plan, from any and all claims, demands, actions, and causes of action which may result from participation in this program.

What information we collect and how we protect that information:
The information collected and the results of your screening contain health information, such as your height, weight, body mass index, cholesterol levels, glucose levels and blood pressure. This health information may constitute "genetic information" if gathered from an employee's family members. The health information we collect from you will be stored using state-of-the-art secure technology to ensure security and confidentiality. Health Advocate follows the HIPAA Security Rule and secures your health information on computer servers in a controlled, secure environment, protected from unauthorized access, use or disclosure. When personal information is transmitted to other websites, it is protected through the use of encryption, such as the Secure Socket Layer (SSL) protocol. In the event of a breach of your Personal Health Information, Health Advocate will notify your employer sponsored health plan pursuant to its business associate agreement with that plan.

How we may use or disclose your information:
Health Advocate will use and disclose your Personal Health Information only as permitted by our business associate agreements with your employer sponsored health plans, as required to by law, or where required by the of U.S. Department of Health and Human Services (HHS) to investigate or determine Health Advocate's compliance with the HIPAA Rules. Under no circumstances will genetic information be used for underwriting purposes. You are not required to provide your health information. The employer may not retaliate against employees who refuse to provide their health information. However, employees who do provide this information may receive an incentive from the wellness program. The employer will not receive any health information that will identify you as an individual unless the employer needs individually identifiable health information for limited purposes of administering parts of the wellness programs. In that case, the employer must agree to implement reasonable safeguards to adequately separate plan administration functions from other employment activities, and to otherwise protect the confidentiality, integrity and availability of the Personal Health Information they utilize on behalf of a group health plan. Minimally identifiable health information will be shared for those administrative purposes. The employer will not receive any individually identifiable genetic information, only genetic information on the aggregate. Your data may be stripped of all identifying information.

and combined with others in a large statistical database for aggregate reporting back to your employer and used for the development and implementation of preventive health programs and resources. Employees may not be discriminated against in employment because of the health information you provide. Employers may not use the health information to make any employment decisions about employees. Employer plan sponsors are also required to implement reasonable safeguards to adequately separate plan administration functions from other employer activities.

Your individual data may be shared with a third party such as disease management vendors who must abide by strict confidentiality and privacy guidelines, and with your written authorization on the previous page, will assist you with chronic condition management and other wellness program services. Your information will not be sold or transferred to, or exchanged or shared with, any third party except if needed to carry out specific activities related to the wellness program. The only other persons who will receive your individually identifiable health information are you and the professionals who need the information to deliver health and wellness services to you.

Authorization

By my signature on the previous page, I hereby authorize Health Advocate or the employer, if necessary, to use or disclose my health information collected during today's screening pursuant to the terms of this Notice and Authorization for the purposes of my continued Health Education or Care Management over the duration of my participation in the wellness program. These services may include care coordination, locating providers, claims/appeal assistance, health coaching, healthy reminders and other wellness services. This Authorization expires upon termination of my enrollment in the wellness program unless another date is indicated.

I further agree, understand, and acknowledge my rights in relation to the following:

- I may refuse to sign this Notice and Authorization. But if I do refuse to provide my authorization, I may not participate in the health screening that is the subject of this authorization.
- A photocopy of this Notice and Authorization will be as valid as the original.
- Health Advocate will ensure my rights of access, amendment and accounting of disclosures with respect to the Personal Health Information it maintains about me on behalf of HIPAA covered entities.
- I have received a copy of this Notice and Authorization, and that I am entitled to a copy of this authorization upon request.
- I may ask questions about the health information collected about me or make requests about this Notice and Authorization by contacting Health Advocate's Privacy Officer at 1-866-385-8033.
- I may also complain to Health Advocate, my employer or group health plan, or the Secretary HHS if I believe my privacy rights have been violated, and no retaliatory actions will be taken against me for filing a complaint.
- I understand that this authorization may be revoked in writing if delivered to Health Advocate although revocation will not be effective as to the disclosure of any information whose release I have previously authorized, or where other action has been taken in reliance on my authorization.