Personal Health Assessment (PHA), Bioscreen, Wellness Program Notice & Consent

Participant First Name (Please type): _____

Participant Last Name (Please type): _____

Participant Date Of Birth (Month/Day/Year): _____

The purpose or need for the disclosure: If applicable, by participating in the Menasha Joint School District ("MJSD") wellness program, you may be asked to complete a voluntary personal health assessment ("PHA") and/or coaching session that present a series of questions about your health-related activities and behaviors and whether you had or have certain medical conditions (e.g., cancer, diabetes, or heart disease). The following is consent to participate in that screening. You also may be asked to complete a bioscreen (lab draw) as part of the program.

Protections from Disclosure of Medical Information: As a covered entity under HIPAA, Coraggio LLC (Doing Business As Mobile Health Team) is required by law to maintain the privacy and security of your personally identifiable health information in accordance with our Notice of Privacy Practices, which you have an opportunity to review and receive a copy upon request. In addition, Coraggio LLC d/b/a Mobile Health Team may use or disclose your information pursuant to your direct authorization, as stated below.

Authorization. I authorize Coraggio, LLC, along with its professional affiliates ("Mobile Health Team"), to collect, use, disclose, and receive information about me for purposes of performing my PHA, biometric screening, and related services. I understand and agree that information may include, but not be limited to, general demographic information, biometric measurements collected (ex: height, weight, blood pressure, waist circumference), and blood specimens and/or bodily fluids collected (ex: cholesterol, HDL, LDL, triglycerides, glucose, etc). If applicable, I understand that if the PHA and biometric screening is sponsored by my employer, a record of my participation may be provided to my employer and my results may be disclosed, in detail, to my health and wellness program administrator in compliance with the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act ("HIPAA"), as applicable, among others. I understand that I may voice concerns to Mobile Health Team about participating in this program and discuss alternatives before signing this form by calling 844-547-0099. I also understand that if I choose not to sign this consent, I will not be processed as a participant in the screening portion of the MJSD wellness program.

Right to Revoke Authorization. I understand that I may revoke this authorization at any time by submitting notice of my revocation in writing to Mobile Health Team, Compliance Department, PO Box 1050, Neenah, WI 54957. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

Effective Time. Expiration date will be four (4) years from date of signature.

Signature Authorization. I have read this form in its entirety and voluntarily consent to the PHA collection and biometrics procedures. I agree to the uses and disclosures of the information as described above. I understand that revoking this authorization does not stop disclosure of health information that has occurred prior to a revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures as provided by HIPAA, 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws. I sign this agreement truthfully, knowingly, freely, and voluntarily. I acknowledge that the person executing this agreement is the person participating in the PHA or receiving the biometric screening, or such participant's legal representative, and is authorized to act on such person's behalf to sign this agreement. The participant is at least 18 years old.

Participant or Legal Representative Signature: _____

Date Signed: _____

Consent to treatment: By signing this form I also give consent to Mobile Health Team and Ann Liebeskind, MD to review my information and work with me as part of the results consultations and/or coaching sessions. Dr. Liebeskind and the Mobile Health Team staff may make suggestions of ways to maintain wellness but this is meant to supplement, not replace, usual medical care by a primary care provider.

Participant or Legal Representative Signature: _____

Date Signed: _____