



**Authorization for the Disclosure of Protected Health Information**

I, the undersigned, understand and agree to the following:

- 1. I have voluntarily scheduled an appointment for Biometric Health Screening (Screening). I understand that I am not obligated to sign this Authorization, to fill out the Personal Health History Questionnaire for the Screening (Questionnaire), or to participate in the Screening. I do not have to participate in the Screening in order to enroll in CIGNA's Well Duo health insurance plan, or to be eligible for medical treatment or coverage under the Plan.
- 2. I consent to the following tests and measurements to be done during my Screening appointment: blood pressure, body composition analysis that includes height, weight, Body Mass Index (BMI), waist measurement, percent body fat, and a blood sample (finger-stick) for the purpose of measuring my Total Cholesterol, HDL Cholesterol, calculated Risk Ratio, and/or Blood Sugar (Glucose).
- 3. My employer has asked Connecticut General Life Insurance Company (CIGNA) and Cigna Medical Group (CMG) CareToday to conduct the Screening. CIGNA and CMG CareToday will receive the results of my Screening and review my responses to the Questionnaire. These companies may use and disclose this information as described below, and I authorize CIGNA and CMG CareToday to use and disclose this information as allowed by law.
- 4. a. My identifiable Protected Health Information from the Screening and the Questionnaire will not be disclosed to my employer. De-identified, aggregate health information may be reported to my employer's Plan.  
 b. CMG CareToday may disclose my Screening results and information on my Questionnaire to CIGNA (if I have enrolled in the CIGNA plan), for use in connection with administration of the plan, and for health care operations.
- 5. I am entitled to receive a copy of this Authorization, the Screening results and the Questionnaire at the end of the appointment.
- 6. **The data derived from these test(s) are preliminary; they are screening assessments only. They are not a diagnosis and are for health information purposes only.**
- 7. **It is my responsibility to schedule a follow-up examination with a medical professional to confirm the results of my Screening and to obtain professional medical help. Follow-up on my Screening results is not the responsibility any organizations associated with the Screening and Questionnaire.**

I hereby release my employer, CIGNA, CMG CareToday, and their affiliates, directors, officers, employees, agents and contractors and any other organization(s) associated with the Screening and Questionnaire, together with their successors and assigns, from any liability arising from or in any way connected with my participation in the Screening and the Questionnaire.

I may revoke this Authorization at any time by providing written notice to CIGNA at 11001 N. Black Canyon Highway, Attn: Jeff Perry, Phoenix, Arizona 85029. Any information released under this Authorization, prior to my revoking the Authorization, will not breach my right to confidentiality. If this information is disclosed to a third party, the information may no longer be protected and may be redisclosed by the person or organization who receives the information. This Authorization will expire one year from the date I have signed below.

The chemical analyzer used to determine plasma glucose and serum lipid levels may provide results that differ from those produced by standard reference laboratory analyzers.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Employee ID#: \_\_\_\_\_

Screening Location: \_\_\_\_\_ Health Plan: \_\_\_\_\_

**Personal Health Questionnaire**

**First Name** \_\_\_\_\_

**Date of Birth** \_\_\_\_\_

**Middle Initial** \_\_\_\_\_

**CIGNA Healthcare ID#** \_\_\_\_\_

**Last Name** \_\_\_\_\_

**Employee ID** \_\_\_\_\_

Questions 1 – 4: Check ALL that apply

Questions 5 – 12: Check only ONE

**1. Do you have a personal history of:**

- Diabetes
- Congestive Heart Failure
- High Blood Pressure
- High Cholesterol (Lipid Lowering)
- Low Back Pain
- Asthma
- Stress and Anxiety
- Depression
- None

**2. Do you have a family history of:**

- Diabetes
- Heart Disease
- High Blood Pressure
- High Cholesterol (Lipid Lowering)
- Depression
- None

**3. How would you describe your tobacco use?**

- Cigar(s)
- Cigarettes
- Pipe(s)
- Smokeless (i.e. chewing tobacco and snuff)
- None

**4. Are you currently taking medications for any of the following?**

- A)
- Diabetes
  - Congestive Heart Failure
  - High Blood Pressure
  - High Cholesterol (Lipid Lowering)
  - Depression
  - Stress and Anxiety
  - Asthma
  - None

**Or any of the following?**

- B)
- Over The Counter (i.e. Baby Aspirin, Cold Medications, etc)
  - Nutritional Supplements (Glucosamine, St John's Wart, etc)
  - Vitamins
  - None

**5. How many medications are you currently taking?**

- 1-2
- 3-4
- None

**6. Are you pregnant?**

- Yes
- No

**7. Do you have a pacemaker?**

- Yes
- No

**8. In an average week, how many times do you engage in moderate physical activity that is done for at least 30 minutes?**

- Less than 1 time per week
- 1 or 2 times per week
- 3 or more times per week
- None

**9. How many servings of food do you eat per day that are high in fiber? For example: fruits, vegetables, or whole grain breads?**

- 1 or 2 servings per day
- 3 or more servings per day
- None

**10. How many servings of food do you eat per day that are high in cholesterol or fat? For example: red meat, dairy, shellfish, processed or fried foods?**

- 1 or 2 servings per day
- 3 or more servings per day
- None

**11. Considering your age, how would you describe your overall physical health?**

- Poor
- Fair
- Good
- Very Good
- Excellent

**12. Have you seen your personal physician in the last year?**

- Yes
- No
- I don't have one

<b><u>For Internal Use Only</u></b>	
Gender _____	Ht _____ Wt _____ Fasting Glucose _____ N/F Glucose _____
TC _____	HDL _____ Risk Ratio _____
Blood Pressure (S) _____ (D) _____	Waist Circumference _____ BMI _____ % Body Fat _____
Best Phone # _____	Alt Phone # _____ Best Day to Call _____ Best Time _____ am / pm
<input type="checkbox"/> HC opt out	