CITY OF BRYAN/BISD
EMPLOYEE HEALTH CENTER

# Wellness Testing Consent

## Authorization for Release of Protected Health Information – Wellness Screening at the Request of Employer

| Patient's Printed Name | | Social Security Number | | Birth Date |
|---|---|---|---|---|
| Address | City | State | Zip | Home Phone Number ( ) |

**SECTION I.** **Applies only to those having blood drawn at the City of Bryan/BISD Employee Health Center or onsite, skip to section II if you are going to an outside medical provider.**

In order to determine certain aspects of my health status through a blood analysis, I hereby consent to engage in the Wellness Exam ("Exam") provided by the City of Bryan/BISD Employee Health Center ("Center"), operated by CHI St. Joseph Health (CHI-SJH). I understand that I am seeking employee health services from a CHI-SJH facility and give my voluntary consent to the attending practitioner or his/her designees(s), including other practitioners, facility personnel, and students to perform and/or administer all screenings, examination, and diagnostic testing (laboratory blood draw) which are included in the City of Bryan Wellness Profile.

I understand that blood will be drawn for laboratory testing. The risks and hazards associated with the withdrawal of blood are bruising, blood clots, tendon or nerve damage, excessive bleeding and/or fainting. I voluntarily agree to assume these risks and will not hold the City of Bryan, CHI-SJH, or the CHI-SJH employees working at the Center liable for any direct or indirect consequences of effects of this test.

I understand Texas law provides that if any healthcare worker is exposed to my blood or other bodily fluid, my blood or other bodily fluid will be tested by this facility to determine the presence of communicable disease, including but not limited to Hepatitis, Human Immunodeficiency Virus (which is the causative agent of AIDS), and Syphilis. I understand such testing is necessary to protect those who will be caring for me while I am undergoing the Exam. I understand that the results of tests performed under these circumstances do not become a part of my medical record.

The information obtained through this Exam will be treated as confidential and will not be released or revealed to any person except upon my written request. I give the Center, operated by CHI-SJH, permission to mail the lab and Exam results to the address provided above.

**SECTION II.** **Applies to ALL participating in the City of Bryan's Wellness Program**

I authorize CHI-SJH, operating as the Center, to disclose to my Employer, City of Bryan that I have participated in the Wellness Screening ("Screening") on the date set forth above, and whether I met the City of Bryan's Screening qualifications. This information will be provided to the City of Bryan-Risk Management Department.

**Expiration** This Authorization for Release of Protected Health Information ("Authorization") shall expire 180 days from the date of signature. I understand this Authorization may be revoked by me at any time except to the extent that action has been taken. I understand that any disclosures already made pursuant to this Authorization are unable to be taken back. I have the right to revoke this Authorization any time prior to its expiration by giving the Center written notice of revocation of this Authorization.

**Re-Disclosure** I understand the information disclosed by this Authorization may be subject to re-disclosure by the recipient and no longer protected by the Health Information Portability and Accountability Act (HIPAA) of 1996.

I understand that:

- I have the right to refuse to sign this Authorization
- I have the right to receive a copy of this Authorization
- I have the right to inspect or copy the protected health information to be used or disclosed
- Fees/charges will comply with all laws and regulations

I have read the above and consent to engage in the Wellness Exam and authorize the disclosure of the protected health information as stated.

**Do you smoke? Please circle one - YES NO**

**DATE** **SIGNATURE of PATIENT/PATIENT REPRESENTATIVE** **RELATIONSHIP TO PATIENT**