

Health Risk Assessment- Alternative Screening Form Instructions (Part One)

Step One: Complete the Authorization for Disclosure of Health Information Form. Send it to Aurora Wellness Services.

Step Two: Complete the top portion of the Alternative Screening Form – be sure to include your email address and print clearly so we can email you a confirmation.

Step Three: Give the Alternative Screening Form to your Primary Care Provider to complete and send to Aurora Wellness Services.

Step Four: Complete the Online Health Risk Assessment with Virgin Pulse.

Please email, mail, or fax the Authorization for Disclosure of Health Information Form and Alternative Screening Form to:

Aurora Health Care
Aurora Wellness Services
Attn: Joan Stigler
11217 West Forest Home Avenue Franklin, WI 53132
Fax: (414) 525-2570 Email: Joan.Stigler@aurora.org

For questions, contact Aurora Wellness Services Department at 1-877-765-3213 Option 1

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION – Marquette University

1) Participant Information: _____
Name of Participant (please print)

_____ (_____) _____
Date of Birth Area Code / Telephone Number

_____ _____
Address City/State/Zip

2) Persons/Organizations Authorized to Disclose
Participant's Health Information:

Aurora Health Care - Aurora Wellness Services
11217 W. Forest Home Avenue, 1E
Franklin, Wisconsin 53132

3) Persons/Organizations Authorized to Receive Participant's Health
Information:

Marquette University (participation information only)
Benefit Services Group, Inc (Marquette's Insurance Broker)
Virgin Pulse (Marquette's Wellness Vendor)

4) Health Information to be Disclosed and Purpose of Disclosure:

- My participation/completion of my biometric screening to Marquette University for the purpose of administering the wellness program incentive benefits.
- Results of my biometric screening to Virgin Pulse (Marquette's Wellness Vendor) for the purpose of data upload into Health Risk Assessment Portal.
- Results of my biometric screening Benefit Services Group (Marquette's Insurance Broker) for the purpose of data management.

5) **Expiration Date:** This Authorization will expire one (1) year from the date signed.

6) **YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:**

Right to Inspect or Copy: I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this Authorization.

Right to Receive Copy of Authorization: I understand that if I agree to sign this Authorization, which I am not required to do, I will be provided with a signed copy of this Authorization.

Right to Refuse to Sign Authorization: I understand that this Authorization is voluntary and that I may refuse to sign this Authorization. Unless allowed by law, my refusal to sign this Authorization will not affect my ability to obtain treatment from Aurora Health Care. *However, I also understand that the wellness/ health services that I receive from Aurora are provided for the purpose of disclosing to the persons/organizations indicated above for the reasons indicated above. Refusal to sign this Authorization may result in a refusal by Aurora to provide me with the specific wellness health services that have been requested.*

Right to Revoke Authorization: I understand that written notification must be presented to the Medical Records Department to cancel this Authorization. I understand that my withdrawal will not be effective as to uses and/or disclosures of health information already made in reliance on this Authorization.

Redisclosure Notice: I understand that if the person(s)/organization(s) listed above are not governed by Federal privacy laws, the health information disclosed as a result of this Authorization may be redisclosed by the recipient and no longer be protected by such laws.

I have had an opportunity to review and understand the content of this Authorization. By signing this Authorization, I am confirming that it accurately reflects my wishes.

7) Signature of Participant: _____ Date: _____

Dear Primary Care Provider,

Your patient is an employee or spouse of an employee at **Marquette University** and is requesting your assistance. In an effort to maintain and improve health and wellness, Marquette University is offering a Health Risk Assessment at no cost. The first part of the Health Risk Assessment is biometric testing. As an alternative to attending an on-site biometric screening, your patient has chosen to utilize the alternative screening option. Measurements taken in your office between **7/1/18 – 11/17/18** can be used towards this year's program. This form must be completed by the provider and faxed directly to Aurora Wellness Services by either the provider or the patient no later than **12PM on November 17, 2018**. **Do not send the results to Marquette University.**

In addition, please make a copy of this form for your patient. They may complete step two of the Health Risk Assessment process by filling out the online Health Risk Assessment (questionnaire) using the results of your biometrics exam.

Thank you in advance for your cooperation with this commendable effort on the part of Marquette University and their partner Aurora Health Care Wellness Services. If you have any questions please feel free to contact the Aurora Wellness Services Department at 877-765-3213, option #1.

Alternative Screening Form – Marquette University

Deadline: November 17, 2018 12PM

SECTION I: TO BE FILLED OUT BY PARTICIPANT (PLEASE PRINT CLEARLY)

Please make sure to send in your Authorization for Disclosure of Health Information form

Date: _____ Company: Marquette University
 First Name: _____ Last Name: _____ 9 Digit Employee ID: _____
 Date of Birth: _____ Home Phone: () _____ (Not SSN#)

Marquette Employee Spouse of a Marquette Employee

Email: _____

An email notification will be sent to patient once Aurora Wellness Services receives this completed form.

Participant Signature: _____

Section II: TO BE COMPLETED BY YOUR PRIMARY CARE PROVIDER

All values must be complete to receive credit

Measurements/lab results must be completed between July 1, 2018 and November 17, 2018

Test Date: _____ Fasting? YES NO

Height:	Total Cholesterol:
Weight:	HDL:
Blood Pressure : /	LDL:
TC/HDL Ratio :	Triglycerides:
Glucose:	

Primary Care Provider Name: _____ Signature _____

PCP's Location/Facility: _____ Phone Number: _____

Comments: _____

Please email, mail, or fax this form to Aurora Wellness Services (do not send it to Marquette University)

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